



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7009 0820 0000 2798 5256

February 13, 2013

Marvin Perry, Administrator
Syringa Chalet Nursing Facility
700 East Alice Street, PO Box 400
Blackfoot, ID 83221

Provider #: 135111

Dear Mr. Perry:

On **February 1, 2013**, a Recertification and State Licensure survey was conducted at Syringa Chalet Nursing Facility by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual 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, and a similar State Form 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.) **Please provide ONLY ONE completion date for each federal and state tag in column X5 Complete Date, to signify when you allege that each tag will be back in compliance.** WAIVER RENEWALS MAY BE REQUESTED ON THE PLAN OF CORRECTION.

Marvin Perry, Administrator

February 13, 2013

Page 2 of 4

After each deficiency has been answered and dated, the administrator should sign both the Form CMS-2567 and State Form in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **February 26, 2013**. Failure to submit an acceptable PoC by **February 26, 2013**, may result in the imposition of civil monetary penalties by **March 18, 2013**.

The components of a Plan of Correction, as required by CMS include:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. This monitoring will be reviewed at the follow-up survey, as part of the process to verify that the facility has corrected the deficient practice. Monitoring must be documented and retained for the follow-up survey. In your Plan of Correction, please be sure to include:
 - a. Specify by job title who will do the monitoring. It is important that the individual doing the monitoring has the appropriate experience and qualifications for the task. The monitoring cannot be completed by the individual(s) whose work is under review.
 - b. Frequency of the monitoring; i.e., weekly x 4, then q 2 weeks x 4, then monthly x 3. A plan for 'random' audits will not be accepted. Initial audits must be more frequent than monthly to meet the requirement for the follow-up.
 - c. Start date of the audits;
- Include dates when corrective action will be completed in column 5.

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.

Marvin Perry, Administrator
February 13, 2013
Page 3 of 4

- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567 and the state licensure survey report, State Form.

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

This agency is required to notify CMS Region X of the results of this survey. We are recommending that CMS impose the following remedy:

Denial of payment for new admissions effective as soon as notice requirements can be met. [42 CFR §488.417(a)]

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **August 1, 2013**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0036, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

go to the middle of the page to **Information Letters** section and click on **State** and select the following:

- BFS Letters (06/30/11)

Marvin Perry, Administrator
February 13, 2013
Page 4 of 4

2001-10 Long Term Care Informal Dispute Resolution Process
2001-10 IDR Request Form

This request must be received by **February 26, 2013**. If your request for informal dispute resolution is received after **February 26, 2013**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,

A handwritten signature in black ink that reads "LORENE KAYSER". The letters are somewhat stylized and slanted.

LORENE KAYSER, L.S.W., Q.M.R.P., Supervisor
Long Term Care

LKK/dmj
Enclosures

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

PRINTED: 02/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135111	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2013
--	--	--	--

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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the annual federal recertification and state licensure survey of your facility.</p> <p>The surveyors conducting the survey were:</p> <p>Arnold Rosling, RN, BSN, QMRP Michael Case, LSW, QMRP</p> <p>Survey Definitions: MDS = Minimum Data Set assessment DON = Director of Nursing LN = Licensed Nurse CNA = Certified Nurse Aide ADL = Activities of Daily Living MAR = Medication Administration Record ROM = Range of Motion BIMS = Brief Interview for Mental Status</p>	F 000	<p>This Plan of Correction is prepared and submitted as required by law. The facility reserves the right to challenge in legal proceedings all deficiencies, statements, findings, facts, and conclusions that form the basis for the deficiencies.</p> <p><u>F 165</u></p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: For the affected residents the facility will ensure that grievance forms will be in the grievance boxes. The facility will establish a process to identify clothing that the residents believe have been lost with the outside laundry service. The facility will develop a log to track grievances and will update the policy related to the grievance process.</p> <p>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: All residents have the potential to be affected by the deficient practice. The facility will revise the policy and procedure outlining the grievance process to reflect current practice and regulations.</p>	
F 165 SS=E	<p>483.10(f)(1) RIGHT TO VOICE GRIEVANCES WITHOUT REPRISAL</p> <p>A resident has a right to voice grievances without discrimination or reprisal. Such grievances include those with respect to treatment which has been furnished as well as that which has not been furnished.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff and resident interviews, grievance files and policy review, it was determined the facility failed to ensure there was a process for residents to file grievances, investigate grievances and resolve grievances. This had the potential to effect 8 of 9 (#s 1 - 5 and 7 - 9) sampled resident and most of the residents in the</p>	F 165		4/14/2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE Administrator DATE 2/25/13

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.

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

PRINTED: 02/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135111	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2013
--	--	--	--

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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 165	<p>Continued From page 1 facility. There was a potential for psychological harm if a resident had a grievance and could not get someone to look into it and formulate a resolution. Findings include:</p> <p>On 1/28/13 at 1:30 p.m. during the initial tour of the facility there were locked grievance boxes at the end of the hallways of 1st street and 2nd street units. There were no forms or paper for residents to write on to file a grievance.</p> <p>During the resident group interview on 1/29/13 at 10:00 a.m. there residents complained about issues of lost clothing and missing items. They indicated that they had discussed it with staff and sometimes items would be found and sometimes not. They further indicated that if things were not found there was never a follow-up of what was done.</p> <p>The grievance log was requested at the entrance conference and was never provided to surveyors.</p> <p>The social worker was interviewed on 1/31/13 at 11:30 a.m. The facility did not have a grievance log. When asked about resident complaints, she indicated that the staff tell her about them and she looks into them. She had no formal system for documenting the issues that were brought to her attention, tracking progress during investigation of the issues or a feedback process about the grievance. She had no process to show that a resident voiced a grievance.</p> <p>The facility policy for "Resident Grievances, Complaints or Requests," Policy Number 210-01B-400, documented under "Procedure" the following:</p>	F 165	<p>(F 165 Continued)</p> <p>What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur: The facility will revise the policy and procedure outlining the grievance process to reflect current practice and regulations.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Administrator or designee will monitor the Social Worker's log for accuracy and completeness weekly x 4, then every 2 weeks x 4, then every month x 3. The Administrator or designee will report on this monitor at quarterly QA/PI meetings and the frequency and duration of the monitors may be adjusted as determined by the PI Committee. These monitors will begin April 1, 2013.</p>	
-------	---	-------	---	--

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

PRINTED: 02/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135111	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2013	
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 165	Continued From page 2 "1. Complete the (facility name) Suggestion/Grievance form, date and sign it. 2. Place the Suggestion/Grievance form into either of the locked Resident's Rights boxes located on 1st Street and 2nd Street [1st and 2nd floors of the facility]. 3. The social worker picks the forms up weekdays, except holidays, and forwards them to the interdisciplinary team. 4. You will receive an acknowledgement of receipt of your grievance. 5. The Interdisciplinary Team will process your grievance with the appropriate supervisory personnel to obtain resolution. 6. The Interdisciplinary Team will review your grievance promptly. You will be provided a written response to your grievance/concern, along with a submitter's acknowledgment form that we ask you to complete and return. We want you to feel your grievance has been addressed or resolved to your satisfaction." The facility failed to ensure residents were afforded the ability to file a grievance as outlined in their policy. The Administrator and DON were informed on 1/31/13 at 5:00 p.m. No further information was provided.	F 165		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a	F 225	<u>F 225</u> What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The process for investigating injuries of unknown origin will be added to the policy on abuse prevention. This process will include how these injuries will be evaluated for patterns or trends.	4/14/2013

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

PRINTED: 02/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135111	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2013
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	<p>Continued From page 3</p> <p>court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure that injuries of unknown origin was investigated to rule out resident abuse or neglect. This was found for 3 of 9 (#s 4, 5 and 6) sampled residents. Not notifying the administrator of and investigating injuries of unknown created the potential for</p>	F 225	<p>F 225 Continued</p> <p>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: All residents have the potential to be affected by the deficient practice. Syringa Chalet Nursing Facility (SCNF) staff will be educated on the process for documentation of and notification of injuries of unknown origin.</p> <p>What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur: Injuries of unknown origin will be documented in the electronic record and an administrative follow-up note will be attached to the original note documenting the results of an investigation into the source of the injury.</p>	

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

PRINTED: 02/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135111	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2013
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	<p>Continued From page 4 residents to be abused or neglected. Findings include:</p> <p>1. Resident #4 was admitted to the facility 4/25/12 with diagnoses of insulin dependent diabetes mellitus type 2, left upper extremity paralysis, vascular dementia and congestive heart failure.</p> <p>The most recent quarterly MDS, dated 1/9/13, documented the resident: * was cognitively intact with a BIMS of 15, * did not have any behaviors, * required extensive to total assistance with bed mobility, transfers, dressing, and personal hygiene, * had functional limitations in range of motion on one side of the body.</p> <p>The resident had a Temporary Problem sheet that documented the resident had "Multiple 1 mm x 1 mm round scratch marks from left shoulder to left upper arm" on 9/24/12. The resident's left arm was flaccid and he could not voluntarily move it. The DON was interviewed, on 1/30/13 at 3:00 p.m., about the lack of an incident report on the injury. The information was logged into another program but there was no formal investigation on how the multiple scratches had occurred.</p> <p>2. Resident #5 was admitted to the facility on 7/31/89, with diagnoses of paranoid schizophrenia, orofacial dyskinesia, frontal lobotomy, moderate mental retardation and dementia.</p> <p>The most recent quarterly MDS, dated 12/5/12, documented the resident: * had short and long term memory problems,</p>	F 225	<p>F 225 Continued</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Director of Nursing (DON) or designee will log injuries into a computer program that will assist in monitoring for patterns or trends. The log will be monitored by the SCNF Administrative Assistant every week x 4, every 2 weeks x4, then every month x 2. The monitor will verify that the injuries are investigated and the source identified if possible. The DON or designee will report on these monitors at quarterly QA/PI meetings and the frequency and duration of the monitors may be adjusted as determined by the PI Committee. These monitors will begin April 1, 2013.</p>	

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

PRINTED: 02/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135111	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2013
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 225	<p>Continued From page 5</p> <ul style="list-style-type: none"> * required total assistance with transfers, dressing, eating, personal hygiene and bathing. * had limitations in Range of Motion for one side upper extremity and both sides for lower extremities. <p>The resident had a "Temporary Problem - Bruising" sheet that documented on 1/7/13 the resident had bruising on the "left upper arm." Review of the nursing progress note revealed there was nothing documented on 1/7/13. The DON was interviewed on 1/30/13 at 3:00 p.m. and indicated the information was logged into another program but there was no formal investigation on how the bruising occurred. No other information was provided.</p> <p>3. Resident #6 was admitted to the facility on 4/1/10 with diagnoses of bipolar and Alzheimer's disease.</p> <p>The most recent annual MDS, dated 1/2/13, documented the resident:</p> <ul style="list-style-type: none"> * had short and long term memory issues, * required total assistance with transfers, dressing, eating, and personal hygiene. * incontinent of bowel and bladder, and * had bilateral upper and lower extremities functional limitations in ROM. <p>The resident had a "Temporary Problem - Bruising/Abrasion" sheet that documented on 1/16/13 the resident had bruising on the "posterior aspect of upper left leg." Review of the nursing progress note revealed there was nothing documented on 1/16/13. The nursing progress notes documented, on 1/21/13 at 9:51 a.m., a "New superficial abrasion noted while performing</p>	F 225			

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

PRINTED: 02/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135111	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2013
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 225	Continued From page 6 weekly skin checks, on posterior aspect of upper left thigh/leg, 6 cm long, 2 cm wide, and .5 cm deep, without drainage or odor, on 1/16/13." The DON was interviewed on 1/30/13 at 3:00 p.m. and indicated the information was logged into another program but there was no formal investigation on how the bruising/abrasion occurred. No other information was provided. The Administrator and DON were notified on 1/31/13 at 5:00 p.m. No further information was obtained.	F 225			
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on review of the facility's policies and procedures, and staff interviews, it was determined the facility failed to ensure policies were adequately developed and implemented to monitor and track patterns of potential abuse, neglect, or mistreatment. This failure affected 9 of 9 (#1 - #9) sample residents and had the potential to impact any individual residing at the facility who sustained an injury of unknown origin. This failure resulted in potential harm by not thoroughly investigating injuries of unknown origin or monitoring for patterns or trends. Findings include:	F 226	F 226 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The process for investigating injuries of unknown origin will be added to the policy on abuse prevention. This process will include how these injuries will be evaluated for patterns or trends. 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: All residents have the potential to be affected by this deficient practice. The process for investigating injuries of unknown origin will be added to the policy on abuse prevention.	4/14/2013	

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 02/01/2013
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	<p>Continued From page 7</p> <p>The facility's Resident Abuse Reporting In Skilled Nursing Facilities policy, effective 10/6/11, stated the policy "provides guidelines for facility response to actions which may be considered abuse, neglect, or exploitation by staff, volunteers, or visitors."</p> <p>The policy stated injuries of unknown origin, defined as injuries whose source was not observed by any person or the source of the injury could not be explained by the resident, were to be immediately reported to the facility's Administrator. However, the policy did not include information related to the investigation or monitoring of injuries of unknown origin.</p> <p>Under the "Procedure" section, the policy stated staff were to complete a Significant Event report (SER) and follow instructions provided in the SER Policy.</p> <p>The facility's SER policy, effective date 4/25/11, stated the purpose of the policy was, "To provide a confidential, protected system for the prompt reporting, complete documentation, and ongoing tracking and trending of patient/resident, staff, visitor, and environmental risk concerns." The policy included the reporting of "Any accident, injury, unexpected outcome or safety concern of a patient/resident."</p> <p>The policy stated any event that qualified as an SER was to be documented by staff in the Patient/Resident SER electronic record. At that point: - The information from the SER Progress Note was transferred to the resident's electronic</p>	F 226	<p>F 226 Continued</p> <p>What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur: SCNF staff members will be educated about the process for documenting and reporting injuries of unknown origin. Patterns and trends related to injuries of unknown origin will be reported on in the quarterly PI/QA Committee Meetings.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Administrator will verify that the policy has been updated with instructions for the process for investigating injuries of unknown origin. The DON or designee will log injuries into a computer program that will assist in monitoring for patterns or trends. The log will be monitored every week x 4, every 2 weeks x4, and then every month x 2. The monitor will verify that the injuries are investigated and the source identified if possible.</p>	

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

PRINTED: 02/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135111	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2013
--	--	--	--

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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 226	<p>Continued From page 8 medical record.</p> <ul style="list-style-type: none"> - The LN assessed and treated any injuries and completed the "Charge Nurse" tab. - The LN submitted the report to the appropriate treatment team. - The LN transferred information from the SER Nursing Assessment/Follow-Up Note to the resident's electronic medical record. - The Clinical Treatment Team reviewed the Patient/Resident SERs and completed a "Treatment Team Review" on a weekly basis. - The Administrative Review Group reviewed the Patient/Resident SERs and completed the "Administrative Review." - The Safety/Risk Manager reviewed Patient/Resident SERs and completed the "Safety Director Review." <p>The policy was not sufficiently developed or implemented, as follows:</p> <p>Upon entrance at the facility on 1/28/13, the survey team was provided with a list of incident/accident reports and later the actual incident/accident reports. The reports were titled "Progress Notes" and included the resident's name, an event number, the date, time, type of event, location, and area of injury (if present). Additional information, such as an event description, medical intervention, others involved, and follow up notes were included.</p> <p>The back side to the Progress Note included a review section listing the review type, disposition, reviewers comments, review date, time, person and closed status.</p> <p>It was not clear how the Progress Note</p>	F 226	<p>F 226 Continued</p> <p>The DON or designee will report on these monitors at quarterly QA/PI meetings and the frequency and duration of the monitors may be adjusted as determined by the PI Committee. These monitors will begin April 1, 2013.</p>	
-------	--	-------	--	--

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

PRINTED: 02/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135111	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2013
--	---	--	---

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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	<p>Continued From page 9</p> <p>documentation provided was consistent with the process for reporting and review as outlined in the SER policy. Additionally, information related to how patterns of potential abuse, neglect, and mistreatment were tracked was not evident.</p> <p>During an interview on 1/31/13 from 11:45 - 11:55 a.m., the Administrator stated the facility used a "72 hour look back" system to review injuries of unknown origin. The Administrator stated the DON reviewed the incidents and would bring them to the Administrator's attention if further investigation was needed. When asked how patterns of potential abuse, neglect, and mistreatment were tracked and trended, the Administrator stated no formal process had been developed. The Administrator stated he and the DON would look at an incident, and if they remembered something similar, the incident would be investigated further. There was lacking any defined criteria for what the DON referred to the administrator.</p> <p>During an interview on with Administrator and the DON on 1/31/13 from 11:58 a.m. - 12:45 p.m., the DON stated staff were to document any injury of unknown origin in the residents' electronic record. When entering the information, the staff were to select "additional signatures," which would alert the person selected that an incident needed to be reviewed. At that point, a 24 hour review would be implemented (not a 72 hour look behind) and all staff with potential information working in the 24 hour period prior to the injuries discovery would be reviewed.</p> <p>The DON stated if the staff entering the information failed to select additional signatures,</p>	F 226		

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

PRINTED: 02/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135111	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2013
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 10 the incident would not be reviewed. The DON stated he had discovered several injuries of unknown origin that had not been reviewed for this reason. When asked how patterns of potential abuse, neglect, and mistreatment were tracked and trended, the DON stated no formal process had been developed. The DON stated the SER policy had not been implemented. Federal guidance at F226, IV. Identification states, in part, "identify events, such as...patterns and trends that may constitute abuse..." As demonstrated by the facility's documentation, and as described by the Administrator and the DON, the facility's policy was not implemented as written. Also, the procedure that was in place did not ensure all injuries of unknown origin were thoroughly investigated. Additionally, there was no formal procedure to monitor for patterns of potential abuse, neglect, or mistreatment. The facility failed to ensure abuse policies were sufficiently developed, implemented, and monitored.	F 226		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced	F 248	F 248 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Activities care plans will be reviewed and updated to reflect resident activities preferences via use of and activities preference worksheet. The Access data base system will be replaced with an Excel data base file for tracking of individual activity attendance, participation, types and frequencies. The activities calendar will be adjusted to encompass both floors and their respective dining times to eliminate "dead time."	4/14/2013

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

PRINTED: 02/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135111	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2013
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 248	<p>Continued From page 11</p> <p>by: Based on staff and resident interviews, record reviews and observations, it was determined the facility failed to ensure there was an activity program to meet the needs of each residents. For 2 of 9 (#s 5 and 9) sampled residents, the activities did not address their individual interests. This had the potential for harm due to the residents psychosocial needs would not be met. In addition, the activity program failed to have variety. Findings include:</p> <p>1. Resident #5 was admitted to the facility on 7/31/89, with diagnoses of paranoid schizophrenia, orofacial dyskinesia, frontal lobotomy, moderate mental retardation and dementia.</p> <p>The most recent quarterly MDS, dated 12/5/12, documented the resident: * had short and long term memory problems, * required total assistance with transfers, dressing, eating, personal hygiene and bathing. * had limitations in Range of Motion for one side upper extremity and both sides for lower extremities.</p> <p>The significant change MDS assessment, dated 9/5/12 documented the resident's activity interests to be getting a shower, between meal snacks, listening to music and doing things with groups. The CAA documented that the resident "has shown a decline in both activities attendance and her participation levels." The resident "is still assisted to and from group activities and activities staff continue to engage [resident name] in 1 : 1 type activities."</p>	F 248	<p>F 248 Continued</p> <p>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: All residents participating in the activities program have the potential to be affected by the deficient practice. Quarterly review of the activities care plan, in conjunction with the quarterly MDS review will be performed for each resident. A new data base (Excel) will be established for monitoring of each individual resident and the activities calendar will be adjusted to provide for each floor dining times.</p> <p>What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur: An activity needs check list will be added and will be presented at each quarterly staffing of individual residents. The check list will include MDS completion, Care plan update, and individual participation summary. In addition resident council will have an additional agenda item added; resident/staff review of monthly calendar to ensure variety/timeliness of unit activities.</p>		

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 02/01/2013
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	<p>Continued From page 12</p> <p>The annual MDS assessment, dated 4/11/12, documented the resident's activity interests as: books, newspapers, and magazines to read, listen to music, be around animal/pets, keep up with news, do things with groups of people, do favorite activity, go outside when the weather was good and participate in religious activities.</p> <p>The resident's care plan dated 12/21/12 documented interventions for Activities of:</p> <p>"1 Daily orient [resident] to daily activities and encourage/assist [resident] to morning orientation/continental breakfast group. 2 Provide [resident] with daily chronicle [sic]. Frequently remind and assist [resident] to scheduled activities. 3 Encourage/assist [resident] to attend montly [sic] resident council and activity planning meetings to discuss potential activities or concerns. 4 [Resident] has enjoyed in the past most offered activities including music, Wii, bowling, bingo, parties, etc. Remind [resident] of these activities and provide assistance getting to those activities as needed. 5 Document [resident] attendance and participation on activity flow sheet."</p> <p>During the survey, the resident was observed to be sleeping in bed (1/29/13 at 9:00 am, 1/30/13 3:00 p.m.), sleeping in her wheel chair in the hall (1/30/13 at 11:30 a.m. 1/31/13 at 11:00 a.m.), or sleeping in the wheelchair in the 1st street day room (1/29/13 at 1100 - 1150 a.m., . The dayroom did have the television on during the day. On 1/31/13 at 3:10 p.m., the activity director was interviewed about Resident #5. He indicated that the resident had "declined mentally and staff</p>	F 248	<p>F 248 Continued</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Administrator or designee will monitor the audits of the daily/monthly calendar every week x4, then every 2 weeks x4, then monthly x 3. The Administrator or designee will also perform 2 random audits of the new Excel data base to assure individual activities data capture every week x4, then every 2 weeks x4, then monthly x3. The Administrator or designee will report on these monitors at quarterly QA/PI meetings and the frequency and duration of the monitors may be adjusted as determined by the PI Committee. These monitors will begin April 1, 2013.</p>	

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

PRINTED: 02/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135111	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2013
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 248	<p>Continued From page 13 cannot get her to things, she makes up her own mind when it comes to participation."</p> <p>Review of the activity calendar for January 2013 showed there was not a lot of variety built into the calendar. There were only 6 programs of interest that were listed on the residents care plan for activities. The calendar showed the following activities planned: * Movies to be shown 31 times with 4 days they were shown twice, * Music on both floors 1 time, * Music on just the 2nd street (floor) 3 times, * Games scheduled for 2 times, * Bingo scheduled for 3 times, * Comedy scheduled for 3 times, and * Canteen run scheduled for 8 times.</p> <p>The resident's activity participation documentation for January 2013 was not available to review. The computer system no longer supported the program the activity person was using. The activity person had not developed an alternate plan to log participation.</p> <p>The Administrator and DON were informed of the activity issue on 1/31/13 at 5:00 p.m. No further information was provided.</p> <p>2. Resident #9 was admitted to the facility on 9/29/11 with diagnoses of diabetes mellitus type II and dementia unspecified; without behavior disturbance.</p> <p>The most recent quarterly MDS assessment, dated 12/5/12, documented the resident; * was cognitively intact with a BIM = 14, * required minimal to moderate assistance for</p>	F 248			

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

PRINTED: 02/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135111	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2013
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 248	<p>Continued From page 14 transfers, dressing, and personal hygiene.</p> <p>The annual MDS assessment, dated 9/5/12, documented the resident's interests were: books, newspapers, and magazines to read, listen to music, be around pets and animals, keep up with the news, do things with groups of people, do favorite activities, go outside when the weather was good, and participate in religious activities.</p> <p>The resident was interviewed on 1/31/13 at 10:00 a.m. The resident indicated in the interview that there was not a lot of variety in the activities at the facility. The resident expressed an interest in: going to meetings, bingo, going out to dinner, van rides [she was not taken sometimes because of her wheelchair], playing Yahtzee and solitaire. She also said that sometimes she would go downstairs and play the piano. The resident further indicated she liked to bowl, swim, go on camping trips, fish and do ceramics. She stated, "I'm very creative, I like to write poetry."</p> <p>The residents care plan for Activities, dated 9/12/12, documented: "3 Encourage [resident] to attend unit activities. Escort [resident] to offered unit activities as needed and offer positive reinforcement and verbal praise for attendance/participation. 4 On those occasions in which [resident] chooses not to attend offered unit activities, provide 1 : 1 solo activity alternatives. 5 [Resident] is an avid Yahtzee player and be provided with game sheets and dice so she may play when she chooses. 7 When in her room, [resident] has a television in her room. [The resident] does not need assistance with the working of the television but</p>	F 248			

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

PRINTED: 02/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135111	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2013
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 248	<p>Continued From page 15</p> <p>will be afforded assistance if she needs it.</p> <p>8 [Resident] has expressed an interest in continuing her practice in the Catholic church. The local parish has been notified and [resident] will be offered the opportunity to visit and take communion with the local priest when he comes to the unit for his visits.</p> <p>9 [Resident] will be invited and encouraged to attend monthly activity planning and resident council meetings where she may include her input, desires, or concern about her activity involvement and events that she would like to do on or off the unit."</p> <p>On 1/31/13 at 3:10 p.m. the activity director was interviewed about Resident #9's activities. He indicated that the resident did refuse to attend activities. He also indicated that the facility had a Wii but had not used it in a while. The residents did do bowling and other programs on it. He indicated that the facility will start using it again. None of the other interests of the resident were addressed in the interview.</p> <p>Review of the activity calendar for January 2013 showed there was not a lot of variety built into the calendar. The calendar showed the following activities planned:</p> <ul style="list-style-type: none"> * Movies to be shown 31 times with 4 days they were shown twice, * Music on Both floors was 1 time, * Music on just the 2nd street was 3 times, * Games scheduled for 2 times, * Bingo scheduled for 3 times, * Comedy scheduled for 3 times, and * Canteen run scheduled for 8 times. <p>The resident did not show an interest in movies</p>	F 248			

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

PRINTED: 02/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135111	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2013
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 248	<p>Continued From page 16</p> <p>and this was the majority of the scheduled activities. The resident's activity participation documentation for January 2013 was not available to review. The computer system no longer supported the program the activity person was using. The activity person had not developed an alternate plan to log participation.</p> <p>3. The facility has two floors and food was delivered at noon to the 1st floor. There was a small kitchen off the dining room that kitchen staff serve the meals out of. The first floor meal started at 12 noon and it took about 15 to 20 minutes to serve the residents. Then the kitchen staff moved the food to the 2nd floor and started serving the residents. This was generally around 12:20 to 12:25 p.m. when the first tray was served to second floor residents. Frequently the morning scheduled activity was on the 2nd floor and was concluded at 11:45 a.m.</p> <p>Observations of the second floor dining room were:</p> <p>* On 1/29/13, the dietary staff arrived at the dining room at 12:35 p.m. to serve the meal. The residents were observed in the dining room by 11:50 a.m. The residents that were waiting for their meals were not engaged or encouraged to socialize while waiting for food to arrive, nor was there any background music playing.</p> <p>* On 1/31/13, the dietary staff arrived in the dining room at 12:20 p.m. to serve the meal. The resident observation of the dining room started at noon. A CNA indicated that the residents had an activity until 11:45 a.m. and the residents just stayed. The television was on low with an adventure show on. The residents were not encouraged to interact and it was quiet in the</p>	F 248			

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

PRINTED: 02/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135111	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2013
--	---	--	---

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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 248	Continued From page 17 dining area. There was no activity staff present. The first resident was served at 12:24 p.m. On 1/31/13 at 3:10 p.m., the Activity Director was interviewed about the observations. He indicated that it was a problem and he would extend the 11:00 a.m. activity to after 12 noon so the residents didn't sit idle or dose off to sleep. The Administrator and DON were informed of the activity issue on 1/31/13 at 5:00 p.m. No further information was provided.	F 248		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure social services were provided for 1 of 9 sampled residents (#3) who were reviewed for behavioral symptoms related to physical, and psychosocial well-being. This had the potential to cause harm if residents were not identified for need of medically-related social services and had avoidable declines in physical, mental or psychosocial well-being. Findings include: Resident #3 was admitted to the facility on 4/12/12 with diagnoses that included pain and depressive symptoms.	F 250	F 250 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The care plan for resident #3 will be reviewed and updated as needed to address his behavioral symptoms as they relate to physical and psychosocial well-being. 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: All residents that have a change in their mood or behaviors have the potential to be affected by the deficient practice. A significant change in status checklist will be developed to prompt the notification of specific disciplines when changes have occurred. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur: A significant change in status checklist will be developed to prompt the notification of specific disciplines when changes have occurred.	4/14/2013

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

PRINTED: 02/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135111	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2013
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	Continued From page 18 Resident #3's Admission MDS, dated 4/18/12, documented a Total Severity Score for depression of 2 (0 - 4 = minimal depression). His Quarterly MDS, dated 12/26/12, documented his Total Severity Score for depression as 11 (10 - 14 = moderate depression). Resident #3's Total Severity Score for depression had increased between 4/18/12 and 12/26/12. However, his record did not include information related to reassessment of his depression. Additionally, his Care Plan addressed delusional thoughts, wandering, and verbal aggression but did not address depression. During an interview on 1/31/13 from 4:15 - 4:20 p.m., the Social Worker stated she had not been present when Resident #3's Quarterly MDS was completed. The Social Worker stated an increased Total Severity Score for depression should have triggered a social service review, but the review was missed. The Social Worker stated Resident #3's depression was not being addressed.	F 250	F 250 Continued The MDS Coordinator or designee will complete the checklist when completing the MDS. The MDS Coordinator or designee will send e-mail notification to the effected disciplines notifying them of the need for follow-up. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Significant Change Checklist will be submitted upon completion to the DON or designee. Once the checklist has been submitted the DON or designee will contact the effected disciplines to verify that they have been alerted to the need for follow-up and will document the contact in the log being kept to verify accuracy of the MDS. These monitors will begin April 1, 2013.	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive	F 272	F 272 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: A side rail assessment will be completed for resident #s 1 and 4.	4/14/2013

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

PRINTED: 02/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135111	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2013
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	<p>Continued From page 19</p> <p>assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure that side rails used on 2 of 9 (#s 1 and 4) sampled residents had been assessed for use</p>	F 272	<p>F272 Continued</p> <p>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: All residents being considered for side rail use have the potential to be affected by this deficient practice. A side rail assessment will be conducted for all residents being considered for the use side rails.</p> <p>What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur: A side rail assessment will be implemented for use at SCNF. This assessment will be completed prior to any resident using side rails.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The SCNF Administrative Assistant will monitor the completion of the side rail assessment for all residents being considered for the use of side rails and will verify that the policy has been updated. These monitors will begin April 1, 2013.</p>	

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

PRINTED: 02/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135111	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2013
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 272	<p>Continued From page 20 and/or safety. This had the potential to harm the residents due to the risk of entrapment in the side rail. Findings include:</p> <p>1. Resident #4 was admitted to the facility 4/25/12 with diagnoses of insulin dependent diabetes mellitus type 2, left upper extremity paralysis, vascular dementia and congestive heart failure.</p> <p>The most recent quarterly MDS, dated 1/9/13, documented the resident: * was cognitively intact with a BIMS of 15, * did not have any behaviors, * required extensive to total assistance with bed mobility, transfers, dressing, and personal hygiene, * used a bed rail daily.</p> <p>The resident's bed was observed to have a side rail during the initial tour on 1/28/13 at 1:30 p.m. The resident used the side rail for moving about in bed</p> <p>The resident's medical record did not have an assessment to ensure that the resident was safe to use the side rails.</p> <p>The DON was interviewed on 1/30/13 at 3:00 p.m. and indicated that an assessment for safe use of the side rail had not been completed. The Don stated the resident used the side rail for moving about in bed.</p> <p>2. Resident #1 was originally admitted to the facility on 4/26/10 with diagnoses that included schizoaffective disorder, diabetes, chronic obstructive pulmonary disease, and congestive heart failure. She sustained a hip fracture on</p>	F 272			

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 02/01/2013
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 21 12/4/12 which required surgical repair. She was readmitted to the facility on 12/14/12. During observation on 1/29/13 from 7:04 - 8:05 a.m. and from 8:45 - 10:25 a.m., Resident #1 was observed to be in bed with upper side rails raised on both sides of the bed. Resident #1's 12/21/12 Care Plan had a hand written addition, dated 1/8/13, which stated "partial side rails for [patient] comfort [with] turning or for assistance for position change." However, her record did not include an assessment that documented the need for, or safety of, the side rails for Resident #1. During an interview on 1/31/13 from 11:58 a.m. - 12:45 p.m., the DON stated an assessment related to Resident #1's side rails had not been completed. The facility failed to ensure appropriate assessment related to Resident #1's need and use of side rails had been completed.	F 272		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than	F 274	F274 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #1 and #2 will have a significant change assessment completed. 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: All residents have the potential to be affected by this deficient practice. A significant change in status checklist will be developed to prompt the assessment to take place when it is determined that a significant change has occurred.	4/14/2013

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 02/01/2013
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 274	<p>Continued From page 22</p> <p>one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview it was determined the facility failed to identify the need for and complete a significant change MDS assessment following falls with fractures that resulted in a decline of function. This was true for 2 of 2 sample residents (#1 and #2) who both sustained hip fractures requiring surgical repair. This failure created the potential for residents' needs to go un-addressed and un-met. Findings include:</p> <p>1. Resident #1 was originally admitted to the facility on 4/26/10 with diagnoses that included schizo affective disorder, diabetes, chronic obstructive pulmonary disease, and congestive heart failure. She sustained a hip fracture on 12/4/12 which required surgical repair. Resident #1 was readmitted to the facility on 12/14/12.</p> <p>Resident #1's record documented her last Annual MDS was completed 3/9/12 and a Quarterly MDS was completed 11/21/12. The Quarterly MDS documented she was independent (code = 0, no assistance needed) with bed mobility, transfer, walking in her room, walking in the corridor, and locomotion on the unit. The Quarterly MDS further documented she required supervision or set up (code = 1) help for dressing, eating, toilet use, and personal hygiene.</p> <p>During observation on 1/28/13 - 1/31/13,</p>	F 274	<p>F 274 Continued</p> <p>What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur: A significant change in status checklist will be developed to prompt the assessment to take place when it is determined that a significant change has occurred. The MDS Coordinator will complete the checklist when completing the MDS to identify the need for a significant change. The MDS coordinator will also complete the checklist when residents are re-admitted to the facility after an acute admission outside of this facility.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Significant Change Checklist will be submitted upon completion to the DON or designee to verify if the resident meets criteria for a significant change assessment. The checklist will be monitored for every resident with each MDS completion and with each Re-admission. These monitors will begin April 1, 2013.</p>	

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 02/01/2013
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 274	<p>Continued From page 23</p> <p>Resident #1 was observed to utilize a wheelchair to move around her room and the facility. Additionally, her 12/21/12 Care Plan included the use of a wheelchair for mobility, a one hour turning schedule while in bed, the use of a shower chair, the use of a Hoyer lift if the resident would not tolerate a 2 person pivot transfer, and partial side rails for comfort with turning and assistance for position change.</p> <p>Further, Resident #1's 12/21/12 Care Plan included a goal to "increase independence in her ability to self perform ADL's from dependent 2 person to extensive one person assistance..."</p> <p>Resident #1 had experienced a decrease in function related to walking and ADL completion. However, Resident #1's record did not include a Significant Change MDS.</p> <p>During an interview on 1/31/13 from 11:58 a.m. - 12:45 p.m., the DON stated the facility had hoped that, once Resident #1 returned from the hospital on 12/14/12 she would return to her base-line functioning. The DON stated a Significant Change MDS should have been completed for Resident #1 once it was clear she had not returned to base-line, but the assessment had been missed.</p> <p>The facility failed to ensure Resident #1 received a Significant Change MDS.</p> <p>2. Resident #2 was admitted to the facility on 12/11/07 and had diagnoses which included mild mental retardation, type II diabetes, neuropathy, vascular dementia, and osteoarthritis. His record documented he had sustained a left hip fracture</p>	F 274			

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

PRINTED: 02/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135111	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2013
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 274	Continued From page 24 requiring surgical repair during a fall on 10/19/12. Resident #2 was readmitted to the facility on 11/2/12. Resident #2's Annual MDS that was completed on 5/9/12 documented he could walk in his room and corridor with physical assistance (code = 3, 2+ persons physical assist) and had occasional pain (code = 3). Resident #2's Quarterly MDS, dated 1/2/13, documented he was no longer able to walk in his room or the corridor (code = 8, did not occur), and that his pain had increased in frequency and intensity to a 9 (unable to assess). Resident #2 had experienced a decline in his ambulatory ability and an increase in his pain. However, a Significant Change MDS had not been completed. During an interview on 1/31/13 from 11:58 a.m. - 12:45 p.m., the DON stated a Significant Change MDS had not been completed.	F 274			
F 278 SS=B	The facility failed to ensure Resident #2 received a Significant Change MDS. 483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the	F 278	<u>F 278</u> What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The MDS assessments for resident #s 4, 6, 8, and 9 will be reviewed for accuracy and corrections submitted as indicated.	4/14/2013	

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

PRINTED: 02/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135111	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2013
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 278	<p>Continued From page 25 assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure that the MDS assessments were accurate. This was true for 4 of 9 (#s 4, 6, 8 and 9) sampled residents. Findings include:</p> <p>1. Resident #4 was admitted to the facility 4/25/12 with diagnoses of insulin dependent diabetes mellitus type 2, left upper extremity paralysis, vascular dementia and congestive heart failure.</p> <p>The most recent quarterly MDS, dated 1/9/13, documented the resident: * was cognitively intact with a BIMS of 15, * did not have any behaviors,</p>	F 278	<p>F 278 Continued</p> <p>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: All residents have the potential to be affected by the deficient practice. All MDS assessments completed since the change to Section N in April 2012 will be reviewed for accuracy and corrections submitted as indicated.</p> <p>What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur: The DON or designee will be notified by the MDS Coordinator upon completion of the MDS assessments. The DON or designee will review each MDS for accuracy upon completion.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The DON or designee will log all MDS assessments verified for correctness in a log every week x4, then every 2 weeks x4, and then every month x3.</p>		

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

PRINTED: 02/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135111	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2013
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 278	<p>Continued From page 26</p> <p>* required extensive to total assistance with bed mobility, transfers, dressing, and personal hygiene.</p> <p>The resident's annual MDS, dated 5/2/12, documented the resident received Psychoactive and Antidepressant medications only 1 time during the review time frames. The resident actually received the medication 7 days during the review time frame. The DON was interviewed on 1/30/13 at 3:30 p.m. and stated the person doing the MDS had mistakenly used the previous coding that was changed April 2012.</p> <p>2. Resident #6 was admitted to the facility on 4/1/10 with diagnoses of Bipolar and Alzheimer's disease.</p> <p>The most recent annual MDS, dated 1/2/13, documented the resident: * had short and long term memory issues, * required total assistance with transfers, dressing, eating, and personal hygiene.</p> <p>The resident's annual MDS, dated 1/2/13, and quarterly MDS, dated 10/3/12, both documented the resident received Psychoactive medications only 1 time during the review time frames. The resident actually received the medication 7 days during the review time frame. The DON was interviewed on 1/30/13 at 3:30 p.m. and stated the person doing the MDS had mistakenly used the previous coding that was changed April 2012.</p> <p>3. Resident #8 was admitted to the facility on 8/14/12 with diagnoses of depression and bipolar disorder.</p>	F 278	<p>F 278 Continued</p> <p>The DON or designee will report on these monitors at quarterly QA/PI meetings and the frequency and duration of the monitors may be adjusted as determined by the PI Committee. These monitors will begin April 1, 2013.</p>		

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

PRINTED: 02/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135111	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2013
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 278	Continued From page 27 The most recent quarterly MDS, dated 11/21/12, documented the resident: * was severely cognitively impaired, * required minimal assistance for transfers, dressing and personal hygiene. The resident admission MDS, dated 8/22/12, documented the resident received Psychoactive medications only 1 time during the review time frames. The resident actually received the medication 7 days during the review time frame. 4. Resident #9 was admitted to the facility on 9/29/11 with diagnoses of diabetes mellitus type II and dementia unspecified; without behavior disturbance. The most recent quarterly MDS, dated 12/5/12, documented the resident: * was cognitively intact, * required minimal to moderate assistance for transfers, dressing, and personal hygiene. Both the resident's annual MDS, dated 9/5/12 and quarterly MDS, dated 12/5/12, assessment documented the resident received Psychoactive medications only 1 time during the review time frames. The resident actually received the medication 7 days during the review time frame. The Administrator and DON were informed on 1/31/13 at 5:00 p.m. No further information was obtained.	F 278			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be	F 280	<u>F 280</u> What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The care plans for resident #3 and #5 will be updated.	4/14/2013	

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

PRINTED: 02/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135111	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2013
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	<p>Continued From page 28</p> <p>incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure that the residents' individual care plans were accurate and up to date with what the resident was doing on a daily basis. This affected 2 of 9 (#s 3 and 5) sampled residents. Not having an accurate care plan created the potential for harm to residents when care that should have been provided was not provided. Findings include:</p> <p>1. Resident #5 was admitted to the facility on 7/31/89, with diagnoses of paranoid schizophrenia, orofacial dyskinesia, frontal lobotomy, moderate mental retardation and dementia.</p>	F 280	<p>F280 Continued</p> <p>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: All residents needing glasses or incontinence undergarments have the potential to be affected by the deficient practice. The care plans for these residents will be reviewed and updated as needed.</p> <p>What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur: The interdisciplinary team will meet to review each residents individual care plan to review it for accuracy. This review will be conducted with each resident's MDS assessment.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The SCNF Administrative Assistant or designee will attend the interdisciplinary team meeting and will take minutes on the meeting. The Administrative Assistant or designee will review the individual care plans to verify items discussed in the team meeting have been addressed in the care plan. These monitors will begin April 1, 2013.</p>	

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

PRINTED: 02/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135111	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2013
--	---	--	---

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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 280	<p>Continued From page 29</p> <p>The most recent quarterly MDS, dated 12/5/12, documented the resident:</p> <ul style="list-style-type: none"> * had short and long term memory problems, * required total assistance with transfers, dressing, eating, personal hygiene and bathing. * had limitations in Range of Motion for one side upper extremity and both sides for lower extremities. <p>The resident's care plan for the problem of "Incontinence" documented an intervention for the resident was to "Use pull-up briefs rather than attends as [Resident #5] has a history of skin irritation."</p> <p>On 1/29/13 at 9:00 a.m. CNA #4 was observed doing peri-care and changed the resident's incontinence brief. The brief was changed using another incontinence brief rather than a pull-up as care planned. When asked the CNA indicated the resident was no longer using pull-ups.</p> <p>The Administrator and DON were informed of the observation on 1/31/13 at 5:00 p.m. and no further information was provided.</p> <p>2. Resident #3 was admitted to the facility on 4/12/12 with diagnoses that included pain and depressive symptoms.</p> <p>Resident #3's Admission MDS, dated 4/18/12, documented he had moderate vision impairment and severe cognitive impairment.</p> <p>A Social Services note, dated 4/18/12, stated Resident #3 reported he did not have glasses, but would like them. The note stated Resident #3 was excited about getting glasses and reported he</p>	F 280		
-------	--	-------	--	--

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

PRINTED: 02/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135111	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2013
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 30 had headaches from not being able to see. An Examination Record, dated 5/24/12, documented Resident #3 had a diagnoses of myopia and astigmatism and required single vision reading glasses. During observations from 1/28/13 - 1/31/13, Resident #3 was not observed wearing glasses. During an interview on 1/31/13 from 4:23 - 4:30 p.m., LN #1 and CNA #2 and #3 were working with Resident #3 and were interviewed regarding his glasses. The LN #1 stated she had never seen Resident #3 with glasses and did not know if he had any. CNA #3 stated he thought Resident #3 was admitted with glasses, but did not know if he had them currently. CNA #2 stated Resident #3 did not have glasses listed on his inventory list. During the same time frame, Resident #3 stated he needed glasses. His glasses observed by the surveyor to be located in a drawer in his room. Resident #3's record documented a need for reading glasses. However, the use of glasses was no incorporated into his Care Plan and facility staff were unaware of Resident #3's vision needs. The facility failed to ensure Resident #3's Care Plan included the need for and use of glasses.	F 280		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores	F 314	<u>F 314</u> What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident # 2 has no unhealed pressure ulcers.	4/14/2013

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

PRINTED: 02/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135111	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2013
--	--	--	--

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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	<p>Continued From page 31</p> <p>does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review it was determined that Resident #6 was harmed when the facility failed to prevent Stage 2 pressure sores from reoccurring. This was true for 1 of 9 (# 6) sampled residents. Findings include:</p> <p>Resident #6 was admitted to the facility on 4/1/10 with diagnoses of bipolar and Alzheimer's disease.</p> <p>The most recent annual MDS, dated 1/2/13, documented the resident: * had short and long term memory issues, * required total assistance with transfers, dressing, eating, and personal hygiene. * incontinent of bowel and bladder, and * had a Stage 2 pressure sore that started on 12/20/12.</p> <p>The resident's comprehensive care plan, dated 1/17/13, documented a problem of; "Potential for pressure development and/or skin breakdown." The interventions were: "1. Assess skin during cares and showers, report any concerns to the charge nurse, 2. Calmoseptine ointment as ordered at bedside for skin protection and redness. 3. Apply Vaseline to both feet after shower and</p>	F 314	<p>F 314 Continued</p> <p>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: All residents that have had a pressure ulcer in the past have the potential to be affected by the deficient practice.</p> <p>What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur: The DON or designee will provide direct-care staff education regarding F-314. This education will include but will not be limited to the importance of revising care plans to promote prevention of and healing of pressure sores. In addition, the education will address proper usage of barrier creams and ointments for protecting resident skin against potential breakdown.</p> <p>Additionally all pressure sores will be treated as injuries of unknown origin and will be investigated to determine the source of the injury and whether the injury was avoidable or unavoidable in nature.</p>	

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 02/01/2013
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 314	<p>Continued From page 32 every morning. Physicians order 8/30/2012. 4. Weekly skin assessment, trim fingernails with each skin assessment. 5. Position resident high in bed so feet will not touch the footboard. 6. When transferring resident please make sure footboard of chair is pushed in and placed back out for his feet to rest on after resident is seated in his chair. 7. Bariatric Rotating Air mattress. Check proper functioning QS [every shift]. 8. Cover all toes on left foot with soft boot during transfers and when in wheelchair. 9. Q2 hour turn schedule. [Started] 12/20/12. 10. ROM exercises per PT [Physical Therapy] recommendations [started] 5/2/2012. 11. Comfort company black foam pressure pad to geri chair. Cover chair with full sheepskin."</p> <p>According to Progress Notes (PN) and other documentation, the resident had pressure ulcers that were first noticed around 10/15/12 and 12/20/12 both Stage II and resolved quickly. The documentation was:</p> <p>- PN 10/17/12 at 12:27 p.m. "Assessment of reported skin breakdown dated 10/15/12. Resident gluteal cleft on the right buttock, 3 small pimple like areas. Area is blanchable, no erythema noted, no open areas, no drainage. Applied Calmoseptine. Will continue to monitor"</p> <p>- PN 10/17/12 at 2:05 p.m. (Addendum to the above note) "Assisted staff with continence care x 2. Calmoseptine applied after each attend change this shift. Resident lying down with support on the left side to encourage pressure relief. Gluteal cleft on right buttocks clean, with barrier applied. No</p>	F 314	<p>F 314 Continued</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The DON or designee will audit the care plan of each resident who has been identified as high risk for pressure sores to promote preventative measures and treatment/healing if needed. These monitors will be done weekly x4, then every 2 weeks x4, then every month x3. The DON or designee will report on these monitors at quarterly QA/PI meetings. The frequency and duration of these meetings may be adjusted as determined by the PI Committee. These monitors will begin April 1, 2013.</p>		

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

PRINTED: 02/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135111	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2013
--	--	--	--

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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 314	<p>Continued From page 33 drainage noted or observed..." - "Physician Progress Note - Medical Clinic" documented about the sore: October 24, 2012 at 12:03 p.m. reason for visit "Stage II pressure ulcer." The note documented: "There is no break down in the gluteal cleft... Skin is intact....Plan: Stage II pressure ulcer resolved."</p> <p>A second pressure ulcer appeared to the same area and it was documented as follows:</p> <p>- On 12/20/12 at 1:00 p.m. a "Nursing Wound Care Note" documented: Pt [patient] seen in his room for wound care to right buttock adjacent to the cleft 1/2 way down.... Erythema: none, Edema: none, Drainage: none, Odor: none, Granulation : none, wound bed: pink and Size/depth: 0.7 cm x 0.6 cm. Dressing: duoderm spot ..."</p> <p>- 12/21/12 at 9:40 p.m. a PN documented, "A PRN [as needed] new duoderm spot applied to right buttock. 0.5 cm X 0.5 cm open area noted. Site appears bright red and superficial. No drainage, active bleeding or odor noted..."</p> <p>- "Physicians Progress Note - Medical Clinic" documented: December 24, 2012 at 2:38 p.m. reason for visit "wound care and 60 day review." The physician documented, "It should be noted that he has a gluteal cleft pressure sore that is being monitored...."Skin: In gluteal cleft there is approximately 0.5 mm annular area where the top layer of skin is removed. There is pink healing skin under this. There is no redness, drainage or odor. Surrounding the area is more intact pink skin where it has healed." The physician documented that it was a "Stage 2 Pressure Ulcer."</p>	F 314		
-------	---	-------	--	--

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

PRINTED: 02/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135111	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2013
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 34 - 12/30/12 at 9:39 p.m. a PN documented, "A new duoderm spot applied to right buttock. 0.5 cm X 0.5 cm pink area noted skin intact..." - On 12/31/12 at 12:18 p.m. the "Nursing Wound Care Note" documented the area was "closed." The resident's spouse was interviewed on 1/30/13 at 1:30 p.m. and indicated that the resident had sores on the buttock at another facility he was at and also had one upon admission to the facility. The DON was interviewed and indicated that the resident had a pressure sore upon admission to the facility. No further information was obtained. The resident had a reoccurring area on the gluteal cleft that reopened. The facility failed to ensure interventions were in place to prevent the redevelopment of Stage II pressure ulcers. The Administrator and DON were informed on 1/31/13 at 5:00 p.m. No further information was provided.	F 314		
F 318 SS=E	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by:	F 318	F 318 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The care plans for residents 2, 3, 4, 5, and 6 will be updated. The care plans will outline specific range of motion exercises as recommended by the facility's Physical Therapist.	4/14/2013

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 02/01/2013	
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 318	<p>Continued From page 35</p> <p>Based on record review and staff interview, it was determined the facility failed to provide ROM services to residents who needed them. This was true for 5 of 9 (#s 2, 3, 4, 5 and 6) sampled residents. Failing to provide ROM to residents who needed the services put them at risk for potential harm related to the development of contractures and and/or decline in functioning of the affected area. Findings include:</p> <p>The DON and Physical Therapist (PT) were interviewed several time during the survey about the need for ROM on residents and the last interview was on 1/30/13 at 3:00 p.m. Five residents were identified with a need for ROM. It was their conclusion that the resident should be receiving at least maintenance ROM if they cooperated with staff. The facility currently did not have a program to address providing residents with ROM if assessed to need it. There was planning during the survey to implement some type of ROM program.</p> <p>1. Resident #5 was admitted to the facility on 7/31/89, with diagnoses of paranoid schizophrenia, orofacial dyskinesia, frontal lobotomy, moderate mental retardation and dementia.</p> <p>The most recent quarterly MDS, dated 12/5/12, documented the resident: * had short and long term memory problems, * required total assistance with transfers, dressing, eating, personal hygiene and bathing. * had limitations in ROM for one side upper extremity and both sides for lower extremities.</p> <p>The resident had a physician's order, dated</p>	F 318	<p>F 318 Continued</p> <p>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: All residents with the potential for decreased range of motion will be evaluated by the physical therapist to determine an individualized plan of care.</p> <p>What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur: A restorative program will be established and training will be provided to nursing staff to provide the appropriate exercises for each individual that the Physical Therapist recommends for admission into the restorative program.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Physical Therapist will meet with the Licensed Nurse in charge of the restorative program to review plan of care for residents admitted into the restorative program every week x4, every 2 weeks x4, and then monthly.</p>	

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 02/01/2013
--	---	--	---

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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 318	<p>Continued From page 36</p> <p>1/31/11, for "ROM BID [twice a day]" and had been renewed by the physician on a monthly basis.</p> <p>The resident's care plan dated 12/21/12 documented a problem of "potential for falls." One of the interventions was; "3. Physicians order : ROM BID." There was no documentation that ROM was being done with the resident.</p> <p>2. Resident #6 was admitted to the facility on 4/1/10 with diagnoses of bipolar and Alzheimer's disease.</p> <p>The most recent annual MDS, dated 1/2/13, documented the resident:</p> <ul style="list-style-type: none"> * had short and long term memory issues, * required total assistance with transfers, dressing, eating, and personal hygiene. * incontinent of bowel and bladder, and * had bilateral upper and lower extremities functional limitations in ROM. <p>The resident was seen on 5/2012 by a PT and it was recommended that the resident have ROM exercises. The residents care plan dated 1/17/13 documented at "Potential for Pressure ulcer development and/or skin breakdown" to have interventions of, "10 ROM exercises per PT recommendation. 5/12/2012."</p> <p>During the survey the resident did not receive any ROM exercises nor was there documentation of services provided.</p> <p>3. Resident #4 was admitted to the facility 4/25/12 with diagnoses of insulin dependent diabetes mellitus type 2, left upper extremity paralysis,</p>	F 318	<p>F 318 Continued</p> <p>The plan of care will be initialed by both parties to verify their review. The SCNF Administrative Assistant or designee will review the care plans of residents in the restorative program to verify the presence of the initials.</p> <p>The Physical Therapist or Licensed Nurse in charge of the restorative program will report on the program at quarterly QA/PI meetings. The frequency and duration of these meetings may be adjusted as determined by the PI Committee. These monitors will begin April 1, 2013.</p>	
-------	--	-------	---	--

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

PRINTED: 02/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135111	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2013
--	--	--	--

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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 318	<p>Continued From page 37 vascular dementia and congestive heart failure.</p> <p>The most recent quarterly MDS, dated 1/9/13, documented the resident: * was cognitively intact with a BIMS of 15, * did not have any behaviors, * required extensive to total assistance with bed mobility, transfers, dressing, and personal hygiene, * had functional limitations in ROM on one side of the body.</p> <p>The resident's medical record documented the resident had a cerebral vascular accident prior to admission and this had left him with a left side paralysis. The residents' left arm was flaccid and he was not able to use it. Review of the residents care plan and interview with the DON and PT Therapist on 1/30/13 at 3:00 p.m. revealed the resident was not receiving ROM. No other information was provided.</p> <p>4. Resident #2 was admitted to the facility on 12/11/07 and had diagnoses which included mild mental retardation, type II diabetes, neuropathy, vascular dementia, and osteoarthritis.</p> <p>Resident #2's most recent quarterly MDS, dated 1/2/13, documented the resident: * was cognitively intact with a BIMS of 15, * required total assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene, * hand functional limitation in ROM on both sides of his body.</p> <p>Resident #2's record documented he sustained a left hip fracture requiring surgical repair during a</p>	F 318		
-------	---	-------	--	--

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

PRINTED: 02/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135111	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2013
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 318	Continued From page 38 fall on 10/19/12. He utilized a wheelchair for mobility. Review of the resident's care plan, and interview with the DON and P.T. on 1/30/13 at 3:00 p.m., revealed the resident was not receiving ROM. The resident's care plan did not include provision for ROM, and no other information was provided. 5. Resident #3 was admitted to the facility on 4/12/12 with diagnoses that included pain and depressive symptoms. Resident #3's most recent quarterly MDS, dated 12/26/12, documented the resident: * was severely cognitively impaired with a BIMS of 00, * required limited assistance in dressing, personal hygiene and bathing, * had functional limitation in range of motion on one side of his body. Resident #3's medical record documented the resident had a total left knee replacement prior to admission and required a walker for ambulation. Review of the resident's care plan, and interview with the DON and physical therapist on 1/30/13 at 3:00 p.m., revealed the resident was not receiving ROM. The resident's care plan did not include provision for ROM, and no other information was provided.	F 318		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	F 323 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The care plan for resident #2 will be updated to include the use of a gait belt. 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: All residents needing gait belts may be affected by this deficient practice. Gait belt use for staff assisted transfers and ambulation will be the expectation at SCNF.	4/14/2013

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

PRINTED: 02/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135111	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2013
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	Continued From page 39 This REQUIREMENT is not met as evidenced by: Based on observation, incident/accident report review, Material Safety Data Sheet (MSDS) review, record review, and staff interviews, it was determined the facility failed to ensure residents were provided with adequate assistive devices to prevent falls for 1 of 9 sample residents (#2) reviewed. Resident #2 was harmed when he sustained a fractured hip as the result of a fall sustained during assistance from the restroom without the use of a gait belt. Additionally, the facility failed to ensure toxic chemicals were maintained under locked conditions. This failure had the potential to cause harm any resident dining in the second floor dayroom, including 9 of 9 sample residents (#1 - #9). This resulted in the potential for cognitively impaired residents to obtain and ingest a toxic substance. Findings include: 1. Resident #2 was admitted to the facility on 12/11/07 and had diagnoses which included mild mental retardation, type II diabetes, neuropathy, vascular dementia, and osteoarthritis. A Progress Note (PN - the facility's incident/accident documentation), dated 9/7/12, stated Resident #2 was walking back from his bathroom stating "I'm going to fall, my hips broken and i'm [sic] going to fall." Resident #2 then began to sit backwards. The staff with Resident #2 grabbed the back of his pants and lowered Resident #2 to a sitting position on the	F 323	F323 Continued What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur: Education will be provided to Syringa Chalet Nursing Facility staff members identifying the use of a gait belt as a standard of care for all residents living at the facility that require assistance with transfers and ambulation and will not require a special notation in individual care plans. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Syringa Chalet Administrative Assistant will maintain a record of the education provided to facility staff members. The Administrator or designee will monitor nursing staff members for gait belt use with a minimum of 2 random checks every week x4, then every 2 weeks x4, then monthly x3. The Administrator or designee will report on these monitors at quarterly QA/PI meetings and the frequency and duration of the monitors may be adjusted as determined by the PI Committee. These monitors will begin April 1, 2013.		

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

PRINTED: 02/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135111	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2013
--	--	--	--

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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 323	<p>Continued From page 40 floor.</p> <p>A PN, dated 9/8/12, stated a staff was assisting Resident #2 from the bathroom to his bed. Resident #2 was using a walker. Resident #2 began to sit before he was close enough to his bed. The staff with him stood behind Resident #2 and assisted "resident to sitting position on the floor." The documentation did not describe how Resident #2 was assisted to the floor.</p> <p>Both PNs included a "Reviewers Comments" section, both dated 9/14/12, which stated nursing staff had been instructed to use a gait belt for all transfers with Resident #2. However, Resident #2's Care Plan did not include the use of a gait belt for transfers.</p> <p>A PN, dated 10/19/12, stated staff were assisting Resident #2 from the bathroom to his wheelchair. Resident #2 was using a walker. Resident #2 stated he was going to "go down." The staff present prompted him to his wheelchair, but Resident #2 let go of the walker and fell to the ground landing on his left hip.</p> <p>NOTE: The PN did not include documentation related to the use of a gait belt by staff.</p> <p>A Follow Up Note included in the PN stated Resident #2 was transported by ambulance to a local hospital. The "Reviewers Comments" section, dated 10/23/12, stated "Resident was admitted to acute care hospital for surgical repair of [left] hip fracture." The review also stated "orders were written for staff members to use a gait belt with all transfers and when assisting with ambulation."</p>	F 323	<p>F 323 Part 2</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The door to the closet that contained a spray bottle of Clockwork sanitizer that was unlocked and not monitored will be fitted with a store room self-locking lock.</p> <p>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: All residents have the potential to be affected by this deficient practice. The door to the closet that contained a spray bottle of Clockwork sanitizer that was unlocked and not monitored will be changed to a store room self-locking lock. The door will lock automatically and a key will have to be used to unlock the door from the hallway.</p>	4/14/2013
-------	--	-------	---	-----------

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

PRINTED: 02/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135111	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2013
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 41 There was no indication the corrective action needed to prevent falls (the use of a gait belt), identified on 9/14/12, had been implemented. The PN did not include information indicating whether or not staff had been using a gait belt at the time of Resident #2's 10/19/12 fall that resulted in a hip fracture. An interview was conducted with the Administrator on 1/31/13 from 11:45 - 11:55 a.m. The Administrator stated follow up on corrective action was to be completed by the treatment team. The Administrator stated a Root Cause Analysis of Resident #2's 10/19/12 fall was completed and found that a gait belt was not used at the time, and the use of the gait belt had not been included in Resident #2's Care Plan. During an interview on 1/31/12 from 11:58 a.m. - 12:45 p.m., the DON confirmed the use of a gait belt had not been included in Resident #2's Care Plan prior to his 10/19/12 fall. According to the Progress Notes, Resident #2 fell on 9/7/12 and 9/8/12 when being assisted from the bathroom. Corrective action identified to prevent falls, dated 9/14/12, stated nursing staff were to use a gait belt for all transfers and ambulation with Resident #2. The use of a gait belt was not included in Resident #2's Care Plan. This resulted in harm to Resident #2 when he fell on 10/19/12 and fractured his left hip, which required surgical repair. The facility failed to ensure corrective action sufficient to protect Resident #2 from falls was implemented and followed.	F 323	F 323 (Part 2) Continued What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur: The Risk Management Officer and the Facility Administrator will survey other storage closets in the facility and determined which doors will benefit from the same locking mechanism as the storage closet door that was found to be deficient on Second Street. The Maintenance Supervisor will replace the locking mechanism to the storage closet on First Street and Second Street with a store room self-locking lock that will not open without a key. Monitoring of this lock will be added to the Syringa Chalet Nursing Home Environmental Safety Hazard Checklist for First and Second Street. This checklist will be completed by nursing staff members during each shift change.	

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

PRINTED: 02/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135111	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2013
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	Continued From page 42 2. Observations were completed at the facility from 1/28/13 - 1/31/13. During meals on the second floor, a closet containing a spray bottle of Clockwork sanitizer was noted to be unlocked and not monitored, as follows: - 1/29/13 from 7:35 - 8:00 a.m. - 1/29/13 from 12:15 - 12:55 p.m. - 1/30/13 at 11:38 a.m. - 1/31/13 at 8:00 a.m. The Material Safety Data Sheet (MSDS) for Clockwork stated "Based on acute toxicity testing, this product is harmful if swallowed." Failure to lock and/or monitor the closet in which the Clockwork sanitizer spray was stored provided opportunity for any resident near the second floor dayroom to access and ingest the chemical. During an interview on 1/31/13 from 11:58 a.m. - 12:45 p.m., the Administrator and Director of Nursing Services both stated the closet was to remain locked at all times and the chemical should not have been left accessible to residents. The facility failed to ensure toxic chemicals were maintained under locked conditions.	F 323	F 323 (Part 2) Continued How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: A completed work order will be submitted to the Facility Administrator upon completion. The Facility Administrator will verify completion of the work order. The Administrator or designee will monitor the completed copies of the Environmental Safety Hazard Checks for completeness every week x4, then every 2 weeks x4, then monthly x 3. The Administrator or designee will report on these monitors at quarterly QA/PI meetings and the frequency and duration of the monitors may be adjusted as determined by the PI Committee. These monitors will begin April 1, 2013. F 371		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The drain under the sink in the main kitchen will be cleaned to promote adequate draining. The drain and hoses for the ice machine will be cleaned.	4/14/2013	

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 02/01/2013
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 43 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure food was stored, prepared, and served under sanitary conditions. This had the potential to impact all residents, including 9 of 10 sample residents (#1 - #8) residing at the facility. This had the potential for cross contamination of food and exposed residents to potential sources of pathogens. Findings include: 1. During the initial tour of the kitchen on 1/28/13 at 10:55 a.m., a kitchen staff was observed to open the drain to the first two sinks on the three-compartment warewashing sink. The drain in the floor-sink utilized by the warewashing sink did not drain at a sufficient rate to accommodate the amount of waste water coming from the warewashing sink. As a result, the wastewater was noted to overflow the floor-sink, run approximately 2 feet across the floor, and run into the cover of the grease trap. The 2009 FDA Food Code, Chapter 6 Physical Facilities, part 6-5 Maintenance and Operation Subpart 6-501 Premises, Structures, Attachments, and Fixtures - Methods, 6-501.11 Repairing, states, Physical facilities shall be maintained in good repair. The Dietary Services Manger, who was present during the initial tour, stated she was unaware the	F 371	F 371 Continued 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: All residents have the potential to be affected by the deficient practice. The drain under the sink in the main kitchen will be cleaned to promote adequate draining. The drain and hoses for the ice machine will be cleaned. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur: Cleaning of the drain will be added to the planned maintenance routine for the main kitchen. The cleaning of the ice machine including the tubes and drain will be added to the planned maintenance schedule. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Dietary Services Manager will visually inspect the drains in the kitchen area to monitor for adequate draining every week x4, then every 2 weeks x4, then monthly x3.	

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

PRINTED: 02/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135111	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2013
--	--	--	--

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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 371	<p>Continued From page 44 drain was slow and needed to be fixed.</p> <p>The facility failed to ensure plumbing fixtures in the kitchen were maintained in good repair.</p> <p>2. On 1/29/13 at 1:45 p.m., an ice machine was noted in the basement of the facility. A CNA, who was present, stated the ice machine was used for residents residing in the facility. The floor-sink utilized by the ice machine was located in the cabinet under the ice machine. The drain and cabinet were dirty. The cabinet contained sawdust and debris, and an orange/red and black residue was noted in the drain. The orange/red and black residue was noted to be covering approximately one inch of the bottom of the drain pipes connected to the ice machine.</p> <p>The debris, along with the orange/red and black residue that was found on the ice machine drain pipes, created potential for contamination of the ice in the machine.</p> <p>During an interview 1/31/13 from 11:58 a.m. - 12:45 p.m., the Administrator and DON both stated the cabinet, drain, and drain pipes should have been cleaned. The Director of Nursing Services stated cleaning was being added to the maintenance check list.</p> <p>The facility failed to ensure the floor-sink utilized by the residents' ice machine was maintained in a sanitary manner.</p> <p>3. The 2009 FDA Food Code, Chapter 4, Part 4-6, Cleaning of Equipment and Utensils, Subpart 4-601.11 Equipment, Food-Contact Surfaces, Nonfood Contact Surfaces, and Utensils</p>	F 371	<p>F371 Continued</p> <p>The Dietary Services Manager or designee will submit a report on these monitors for quarterly QA/PI meetings. This monitor will start April 1, 2013.</p> <p>The Facility Administrator or designee will visually inspect the drain and tubing for the ice machine every week x4, then every 2 weeks x4, then monthly x3. The Facility Administrator or designee will submit a report on these monitors for quarterly QA/PI meetings. This monitor will start April 1, 2013.</p> <p>F 371 (Part 2)</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The microwave will be cleaned and 2 splatter guards will be provided to promote a clean microwave.</p> <p>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: All residents using the microwave on 1st Street had the potential to be affected by the deficient practice. The microwave will be cleaned and 2 splatter guards will be provided to promote a clean microwave.</p>	4/14/2013
-------	---	-------	--	-----------

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

PRINTED: 02/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135111	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2013
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 371	<p>Continued From page 45 indicates, (C) Non food-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris.</p> <p>During an environmental review on 1/30/13 from 9:58 - 11:30 a.m., the microwave located in the first floor dayroom, which was used for the residents, was observed to contain multiple food spills and splatters.</p> <p>During an interview on 1/31/13 from 11:58 a.m. - 12:45 p.m., the Administrator and Director of Nursing Services both stated the microwave should be cleaned anytime there are food spills.</p> <p>The facility failed to ensure the microwave was cleaned.</p>	F 371	<p>F 371 (Part 2) Continued</p> <p>What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur: Microwave cleanliness will be added to the Syringa Chalet Nursing Home Environmental Safety Hazard Checks list for 1st Street. This checklist will be completed by nursing staff members that are beginning and ending their shift at each shift change.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Administrator or designee will monitor the completed copies of the Environmental Safety Hazard Checks for completeness every week x4, then every 2 weeks x4, then monthly x 3. Additionally the Administrator or designee will conduct 2 random checks of the microwave on 1st Street every week x4, then every 2 weeks x4, then monthly x 3. The Administrator or designee will report on these monitors at quarterly QA/PI meetings and the frequency and duration of the monitors may be adjusted as determined by the PI Committee. These monitors will begin April 1, 2013.</p>		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001780	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2013
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	16.03.02 INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiencies were cited during the annual licensure survey of your facility. The surveyors conducting the survey were: Arnold Rosling, RN, BSN, QMRP Michael Case, LSW, QMRP	C 000	This Plan of Correction is prepared and submitted as required by law. The facility reserves the right to challenge in legal proceedings all deficiencies, statements, findings, facts, and conclusions that form the basis for the deficiencies.	
C 121	02.100,03,c,v v. Is encouraged and assisted, throughout his period of stay, to exercise his rights as a patient/resident and as a citizen, and to this end may voice grievances and recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; This Rule is not met as evidenced by: Refer to F165 as it relates to resident greviances.	C 121	C 121 – Refer to F 165 for plan of correction. 	
C 168	02.100,12,c c. An incident-accident record shall be kept of all incidents or accidents sustained by employees, patients/residents, or visitors in the facility and shall include the following information: This Rule is not met as evidenced by: Refer to F225 as it relates to not having an incident report for injuries.	C 168	C 168 – Refer to F 225 for plan of correction	

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
STATE FORM 6899

TITLE
Administrative
(X6) DATE
2/25/13
If continuation sheet 1 of 4

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001780	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2013
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 325	02.107,08 FOOD SANITATION 08. Food Sanitation. The acquisition, preparation, storage, and serving of all food and drink in a facility shall comply with Idaho Department of Health and Welfare Rules, Title 02, Chapter 19, "Rules Governing Food Sanitation Standards for Food Establishments (UNICODE)." This Rule is not met as evidenced by: Refer to F371 as it relates to sanitation in the kitchen.	C 325	C 325 – Refer to F 371 for plan of correction	
C 674	02.151,01 ACTIVITIES PROGRAM 151. ACTIVITIES PROGRAM. 01. Organized Program. There shall be an organized and supervised activity program appropriate to the needs and interests of each patient/resident. The program shall be designed to include a variety of processes and services which are designed to stimulate patients/residents to greater self-sufficiency, resumption of normal activities and maintenance of an optimal level of psychosocial functioning. It shall include recreation, therapeutic, leisure and religious activities. This Rule is not met as evidenced by: Refer to F248 as it relates to activities.	C 674	C 674 – Refer to F 248 for plan of correction	
C 696	02.152 SOCIAL SERVICES 152. SOCIAL SERVICES. The facility shall provide for the	C 696	C 696 – Refer to F 250 for plan of correction	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001780	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2013
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 696	Continued From page 2 identification of the social and emotional needs of the patients/residents either directly or through arrangements with an outside resource and shall provide means to meet the needs identified. The program shall be accomplished by: This Rule is not met as evidenced by: Refer to F250 as it relates to social services.	C 696		
C 782	02.200,03,a,iv iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Refer to F280 as it relates to updating a care plan.	C 782	C 782 – Refer to F 280 for plan of correction	
C 786	02.200,03,b,ii ii. Good body alignment and adequate exercises and range of motion; This Rule is not met as evidenced by: Refer to F318 as it relates to ROM.	C 786	C 786 – Refer to F 318 for plan of correction	
C 789	02.200,03,b,v v. Prevention of decubitus ulcers or deformities or treatment thereof, if needed, including, but not limited to, changing position every two (2) hours when confined to bed or wheelchair and opportunity for exercise to promote circulation; This Rule is not met as evidenced by: Refer to F314 as it relates to Pressure sores.	C 789	C 789 – Refer to F 314 for plan of correction	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001780	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2013
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 790	02.200,03,b,vi vi. Protection from accident or injury; This Rule is not met as evidenced by: Refer to F323 as it relates to protecting residents from injury.	C 790	C 790 – Refer to F 323 for plan of correction	