



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: 7012 1010 0002 0836 1772

March 26, 2014

Tamara K. Gillins, Administrator
Syringa Chalet Nursing Facility
700 East Alice Street, PO Box 400
Blackfoot, ID 83221-0400

Provider #: 135111

Dear Ms. Gillins:

On **March 14, 2014**, 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 one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies, 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) and on or before the "Opportunity to Correct" (listed on page 3). **Please provide ONLY ONE completion date for each federal and state tag in column (X5) Completion Date, to signify when you allege that each tag will be back in compliance.** WAIVER RENEWALS MAY BE REQUESTED ON THE PLAN OF CORRECTION. After each deficiency has been answered and dated, the administrator should sign both Form CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in

Tamara K. Gillins, Administrator
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the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **April 8, 2014**. Failure to submit an acceptable PoC by **April 8, 2014**, may result in the imposition of civil monetary penalties by **April 28, 2014**.

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 will you make to ensure that the deficient practice does not recur;
 - How the corrective action(s) will be monitored to ensure the deficient practice does not recur, i.e., what quality assurance program will be put into place. 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 have 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.
- The administrator must sign and date the first page of both the federal survey report, Form

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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*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **April 18, 2014 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **April 18, 2014**. A change in the seriousness of the deficiencies on **April 18, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **April 18, 2014** includes the following:

Denial of payment for new admissions effective **June 14, 2014**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **September 14, 2014**, 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 Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0036; phone number: (208) 334-6626; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS

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Regional Office or the State Medicaid Agency beginning on **March 14, 2014** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

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

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

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

- BFS Letters (06/30/11)

[2001-10 Long Term Care Informal Dispute Resolution Process](#)
[2001-10 IDR Request Form](#)

This request must be received by **April 8, 2014**. If your request for informal dispute resolution is received after **April 8, 2014**, 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,



DAVID SCOTT, R.N., Supervisor
Long Term Care

DS/dmj
Enclosures

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

PRINTED: 03/25/2014
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 03/14/2014
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NAME OF PROVIDER OR SUPPLIER SYRINGA CHALET NURSING FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 700 EAST ALICE STREET BLACKFOOT, ID 83221
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the annual Federal recertification survey of your facility.</p> <p>The surveyors conducting the survey were: Linda Kelly, RN, and Sherri Case, LSW, QMRP.</p> <p>The survey team entered the facility on 3/10/14 and exited the facility on 3/14/14.</p> <p>Survey Definitions:</p> <p>ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status CNA = Certified Nurse Aide CPR = Cardiopulmonary resuscitation DNS/DON = Director of Nursing Services LN = Licensed Nurse MDS = Minimum Data Set assessment PT/CNA = Psych Tech/Certified Nurse Aide PTT/CNA = Psych Tech in Training/Certified Nurse Aids</p>	F 000		
F 241 SS=E	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure residents were offered cloth napkins to assist them to have a dignified dining experience. This was true for 2</p>	F 241	<p>F241</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Residents #3, 8, 13, and 15-18 were asked their preferences regarding a cloth napkin, clothing protector or both. Care plans updated to reflect individual choices.</p> <p>Continued</p>	<p>4-18 2014</p>

RECEIVED
APR - 8 2014
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Tamara Sheline</i>	TITLE <i>Administrator</i>	(X6) DATE <i>4/7/14</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	<p>Continued From page 1</p> <p>of 9 sampled residents (#s 3 & 8), and 5 random residents (#s 13, 15-18) observed during meals. The facility's failure to ensure residents were offered a cloth napkin rather than a clothing protector (a modified towel tied around the neck) placed them at risk to view themselves or be viewed by others as less than able to meet their own dining needs. Findings include:</p> <p>* During an evening meal observation, on 3/10/14 at approximately 5:20 p.m., CNA #4 approached Resident #16 and ask if she could put a clothing protector on him. The CNA then offered to put a clothing protector on Resident #8 and offered to assist Resident #15 with a clothing protector. The CNA did not offer Resident #13 or any of the other residents a napkin.</p> <p>*During the lunch meal observation on 3/11/14 at approximately 11:45 a.m., CNA #1 offered clothing protectors to Residents #s 17 and 18. Resident #3 was offered assistance with her clothing protector. The residents were not offered a cloth napkin. Resident #13 was the only resident without a clothing protector.</p> <p>When asked if the residents were offered cloth napkins, CNA #1 replied that Resident #13 did not use a clothing protector and she was going to get him a napkin at the time the surveyor began to talk with her. CNA #1 provided a napkin to Resident #13 after the conversation with the surveyor.</p> <p>* During the evening meal observation on 3/12/14 at 5:10 p.m. a clothing protector was placed on the table beside Resident #16. LN #3 asked Resident #15 and #8 if they would like assistance with their clothing protectors. Resident #13 did</p>	F 241	<p>How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken: All residents have the potential to be affected by the deficient practice. Residents were asked their preferences, and care plans will be updated to reflect individual choices.</p> <p>What measures will be put in place or what systemic change will you make to ensure that the deficient practice does not recur: A list of residents and their preferences will be kept on each floor in the day rooms to ensure staff are respectful of resident choices. Staff educated at in-service held 4/9 regarding deficiency and corrective action.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice does not recur, i.e., what quality assurance program will be put into place: Activities Director or Designee will monitor 2 meals weekly x 4, then 1 meal weekly q 2 weeks x 4, then 1 meal monthly x 3 to ensure compliance. The Activities Director will report on audits at quarterly QA/PI Meetings. Audits to start 4/10.</p>		

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F 241	Continued From page 2 not have a clothing protector or a cloth napkin. None of the residents in the dining room were offered a cloth napkin. When asked if the facility had linen napkins, LN #3 showed the surveyor a linen napkin from the closet in the dining room. On 3/12/14 at 7:15 p.m. the Administrator and the DON were informed of the above concern. The facility provided no further information.	F 241		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure a resident's call light was accessible. This was true for 1 of 9 sample residents (#6). This created the potential for unmet needs and/or emotional distress when assistance was needed or wanted. Findings included: Resident #6 was admitted to the facility with multiple diagnoses which included paranoid psychosis, depression, obsessive compulsive disorder, and diabetes mellitus.	F 246	F246 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #6 A call light clip was placed on resident's bed and staff will ensure call light is within reach (See measures described below to ensure compliance). 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: All residents have the potential to be affected by the deficient practice. "Call light clip on Bed" and "Call light within reach" will be added to the "Resident Care/Environmental Safety Hazards Checklist" which is completed each shift during rounds. Staff to correct problems when encountered with a notation made regarding the problem. Administrator or Designee reviews checklist daily M-F looking for trends and patterns and addressing problems requiring administrative attention. Staff educated at in-service held 4/9. Continued	4-18 2014

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F 246	<p>Continued From page 3</p> <p>The resident's most recent quarterly MDS assessment, dated 12/11/13, coded, in part:</p> <ul style="list-style-type: none"> * intact cognition with a BIMS score of 14; * extensive 2 person assistance for bed mobility/transfers/toileting/personal hygiene; * frequent urinary and bowel incontinence; * pain, however, resident unable to answer questions about frequency and intensity; and, * pain made it difficult to sleep at night and limited day-to-day activities over past 5 days. <p>On 3/11/14 at 9:05 a.m. and 9:35 a.m., the resident was observed asleep in bed and the call light was on the floor about 2 feet from the bed.</p> <p>On 3/11/14 at 10:35 a.m., the resident was still asleep; this time however, the call light was on the bed within the resident's reach.</p> <p>On 3/12/14 at 9:55 a.m., the resident was asleep in bed. The call light was on the floor next to the bed and the call light cord was in between the mattress and the bed rail on the resident's left side.</p> <p>On 3/12/14 at 10:00, the resident was awake in bed and the call light was still on the floor. When asked how he let staff know when he needed or wanted something, the resident stated, "That button thing." The resident then looked around the bed for the call light and found the cord between the mattress and side rail. The resident tugged on the call light cord but was unable to pull up the call light itself. The surveyor activated the call light.</p> <p>On 3/12/14 at 10:05 a.m., PT/CNA #2 entered the resident's room, picked up the call light off the floor, and placed it on the bed next to the</p>	F 246	<p>What measures will be put in place or what systemic change will you make to ensure that the deficient practice does not recur: Administrator to address trends and patterns with individual shifts/staff as needed and will address problems at monthly staff meetings.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice does not recur, i.e., what quality assurance program will be put into place: Administrative Assistant to monitor accessibility of call lights by checking resident rooms 3 times weekly x 4, then q 2 weeks x 4, then monthly x 3 to ensure compliance. Audit results reported at Quarterly QA Meetings. Audits to start 4/10.</p>	

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F 246	Continued From page 4 resident. When asked about the call light, the PT/CNA acknowledged that the call light had been on the floor and was not accessible to the resident.	F 246			
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 incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. 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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it	F 280	F280 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #4 Care plan updated (with interventions dated) regarding current level of assist needed with transfers. Resident #2 Care plan updated (with interventions dated) regarding current fall prevention interventions. Resident #1 Care plan updated (with interventions dated) regarding current code status. 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: Since all other residents could be affected by this faulty practice, all care plans will be reviewed and revised by IDT (with interventions dated) to reflect current status. Continued	4-18 2014	

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F 280	<p>Continued From page 5</p> <p>was determined the facility failed to revise care plans to reflect residents' current status. This was true for 3 of 6 sample residents (#s 1, 2, and 4). This failure created the potential to result in harm if: all staff did not assist to transfer Resident (#4) as required; staff did not know what fall prevention interventions were supposed to be in place for Resident #2; and, staff provided unwanted CPR after Resident #1's code status was changed to DNR (do not resuscitate). Findings include:</p> <p>1. Resident #4 was admitted to the facility on 10/11/12 with multiple diagnoses which included schizoaffective disorder, chronic airway disorder and renal insufficiency.</p> <p>The resident's 3/14 ORC Current Orders (recapitulation Physician Orders) included, "If pt. (patient) is moved out of bed please use three people to transfer to help reduce the risk of skin tears."</p> <p>Resident #4's 10/11/12 ADL Care Plan included in the interventions, "Extensive 1-2 staff assist in her ADLs." Note: The Care Plan did not document the date the interventions were implemented.</p> <p>On 3/11/14 at 11:50 a.m. CNA #5 stated the resident stayed in bed except for showers and on occasion would get up for meals.</p> <p>On 3/13/14 at 4:30 p.m. CNA #4 and CNA #7 stated there were no residents who required more than 2 persons to transfer. On 3/14/14 at 10:00 a.m., CNAs #5 and #8 stated Resident #4 was a 3 person transfer and the resident's care plan would identify how many staff were needed to transfer a resident.</p>	F 280	<p>What measures will be put in place or what systemic change will you make to ensure that the deficient practice does not recur: Resident care plans will be reviewed and revised with MDS assessments or when resident status changes. MDS Coordinator attending training in Las Vegas 4/7-4/9. Along with review of the Cardex, a 24 hr. report sheet will be started at shift change alerting staff to critical issues (skin issues, recent falls, change in mood/behavior, critical labs, new medications, change in level of assistance etc.). Additionally, a communication binder will be started that will include additional pertinent resident information/care plan changes that staff can read and initial at shift change. Staff educated on these changes at in-service 4/9.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice does not recur, i.e., what quality assurance program will be put into place: Administrator and DNS will review care plans weekly x 4, then q weeks x 4, then monthly x 3 to ensure care plans reflect changes and interventions are dated. Audit results reported at Quarterly QA Meetings. Audits to begin 4/14.</p>	

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F 280	<p>Continued From page 6</p> <p>On 3/13/14 at 6:15 p.m. the Administrator, Social Worker and Physical Therapist were informed the resident's care plan had not been revised to use three people to transfer the resident. The facility provided no further information.</p> <p>2. Resident #2 was admitted to the facility on 3/7/10 with diagnoses which included paranoid schizophrenia, psychosis and diabetes mellitus II.</p> <p>Resident #2's most recent MDS assessment, dated 1/29/14, documented:</p> <ul style="list-style-type: none"> - Severely impaired cognitive deficit. - Extensive assistance of 2 for bed mobility and transfers. - Unsteady moving from a sitting to standing position, transferring on and off the toilet, and for other surface to surface transfers. - 3 falls since the previous MDS assessment. <p>Facility Progress Notes documented three between falls from 11/30/13 and 3/7/14:</p> <p>* On 11/30/13 at 7:00 a.m. Resident "dropped his weight" and stated he had fell on his right hip the previous evening and did not tell anyone The resident stated he was reaching for blankets on top of his closets. The reviewers' comments were, "Resident encouraged to call for assistance when needed."</p> <p>* On 12/15/13 at 2:20 p.m. Staff found resident sitting on the floor at the side of his bed with his left shoulder resting on bed mattress and sitting on left hip. The follow up notes documented the nurse had "just been in resident's room to assess his hip pain and resident was rolling around in bed prior to the fall." The resident was sent to the</p>	F 280		
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F 280	<p>Continued From page 7</p> <p>hospital and the radiology report, dated, 12/15/13, documented a fracture of the left greater-trochanter (hip). The 12/16/13 orthopedic consult documented a "closed greater trochanter fracture left."</p> <p>* On 12/28/13 at 8:40 p.m. The resident was able to walk and transfer into a shower chair. The resident was transferring from the shower chair to his wheelchair and went to his knees. Nurse's notes documented the resident stated, "You're not going to get away with this, it is not my turn to shower." The reviewer's comments for the fall concluded the resident was, "uncooperative" and there were no injuries.</p> <p>Resident #2's 1/10/12 current care plan (in place on 3/10/14) included the focus area, "Risk for Falls":</p> <ul style="list-style-type: none"> - Encourage resident to use call light and to ask for assistance as needed; - Maintain a clutter free room and clear floor; - Offer resident his 2 wheeled walker for stability. Prompt (resident name) for proper use of walker as needed; - Mattress between bed and wall for safety precautions since resident has a history of leaning to the edge of the bed; - Tab alarm when in bed. <p>NOTE: There was no date of implementation for any of the above interventions.</p> <p>The surveyor requested the Care Plan in place when the resident fell on 11/30/13. The facility provided two additional Care Plans (from the closed chart), both dated 1/10/12. The only difference in interventions for one of these Care Plans and the current care plan was a hand</p>	F 280		

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F 280	<p>Continued From page 8</p> <p>written intervention for "15 minute fall safety checks" dated 1/29/14 and signed by LN #9.</p> <p>The second Care Plan did not have the intervention for the tab alarm in bed and had the following hand written interventions: 12/15/13- "close monitor 1:1 (one to one) and 2 person assist between wheelchair and bed." The intervention was discontinued on 12/20/13 12/17/13- "Please use tab alarm while in bed." Discontinued on 12/23/13 12/23/13- "15 min[ute] safety checks, Place pressure alarm to bed to assist in monitoring Res[ident] movements." 1/6/14 - "1:1 close monitor-Place on 15 minutes safety checks. Tab alarm on bed and wheelchair. Discontinue pressure alarm in bed."</p> <p>The resident's medical record contained documentation that 15 minute checks were done from 12/23/13 to 3/9/14.</p> <p>On 3/13/14 at 2:30 p.m. the MDS Coordinator was asked about the interventions of 15 minute safety checks. The Coordinator stated she was not aware the handwritten interventions needed to be transferred to the current care plan.</p> <p>The Administrator was informed of the above concerns on 3/14/14 at 4:00 p.m. The facility provided no further information.</p> <p>Refer to F514, regarding incomplete medical records, for additional information.</p> <p>3. Resident #1 was readmitted to the facility in October 2013 with multiple diagnoses which included schizo affective disorder; dementia; chronic renal insufficiency, stage 4; interstitial</p>	F 280		

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F 280	Continued From page 9 nephritis; and, history of bilateral hip fractures. The resident's clinical record contained an Idaho Physician Orders for Scope of Treatment (POST), dated 12/16/13, which directed DNR and comfort measures only. The care plan, dated 10/10/13, however, documented the resident's code status was full code. On 3/13/14 at about 6:20 p.m., the Social Worker (SW) was asked about the resident's code status. The SW said the resident's care plan was revised after a POST was completed in December 2013. When informed the care plan documented full code, the SW indicated she would review the resident's clinical record and get back with the surveyor. The Administrator and Assistant Hospital Administrator were present during the interview. On 3/14/14 at 9:00 a.m., the SW acknowledged the resident's care plan did not reflect the change of code status to DNR and comfort measures only. The SW said the care plan would be revised immediately.	F 280			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, record review, and policy review, it was determined the	F 281	F281 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Residents # 6,11, 15 Licensed Nurses will administer BG checks per policy and professional standards of quality. Continued	4-18 2014	

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F 281	<p>Continued From page 10</p> <p>facility failed to ensure the implementation of acceptable standards of practice related to blood glucose (BG) checks. This affected 3 of 7 residents (#s 6, 11 and 15). The failures created the potential for:</p> <p>*Resident #11 to experience pain and/or tenderness when the center of her thumb was stuck to obtain blood for a BG;</p> <p>*Inaccurate BG results for Resident #6 when one nurse used alcohol to wipe away the first drop of blood and another nurse used the first drop of blood.</p> <p>In addition, a nurse pre-documented an insulin injection in Resident #15's left arm then administered it in the resident's right arm. Findings include:</p> <p>Note: Clinical Nursing Skills, 7th edition, 2010, by Perry and Potter, pages 1155 and 1156, stated, "...9 Choose puncture site. Puncture site should be vascular. In adult, select lateral side of finger; be sure to avoid central tip of finger, which has more dense nerve supply...11 Clean site with antiseptic swab, and allow it to dry completely...Alcohol can cause blood to hemolyze...14 Wipe away first droplet of blood with cotton ball... First drop of blood may contain more serous fluid than blood cells...15 Lightly squeeze puncture site (without touching) until large droplet of blood has formed...16 Obtain test results..." And, the Lippincott Manual of Nursing Practice, ninth edition, 2010, by Lippincott, Williams and Wilkins, page 947, stated, "Blood Glucose Monitoring Technique...Prick the patient's finger lateral to the fingertip using lancet/lancing device... [Rationale] This avoids the most sensitive area of the fingertip..."</p> <p>1. On 3/11/14 at 12:15 p.m., LN #9 was observed</p>	F 281	<p>How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken: All other residents requiring BG checks could be affected by the deficient practice. Licensed Nurses will be educated on and observed following policy and professional standards of quality to ensure competency during in-service held 4/9. Additionally, staff will complete a hand hygiene computer module.</p> <p>What measures will be put in place or what systemic change will you make to ensure that the deficient practice does not recur: All licensed nurses tested regarding competency in BG checks at new employee orientation and annually. BG caddies stocked with needed supplies and protective barriers.</p> <p>What the corrective action(s) will be monitored to ensure the deficient practice does not recur, i.e., what quality assurance program will be put into place: DNS to monitor compliance by observing BG checks 2 x weekly x 4, then 1 x weekly x 4, then monthly x 4. Audit results reported at Quarterly QA Meetings. Audits to start 4/14.</p>	
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F 281	<p>Continued From page 11</p> <p>as she stuck a lancet in the center of Resident #11's left thumb to obtain blood for a BG check. The resident yelled, "Owe" and pulled her hand away. The LN responded, "This is the thumb she prefers."</p> <p>On 3/14/14 at 4:00 p.m., the Administrator was informed of the issue. No other information was received from the facility regarding the issue.</p> <p>2. Note: On 3/11/14, the DNS provided a Blood-Glucose Monitoring policy and procedure (number 511-05E-400), per the surveyors request. It documented, in part, "Specimen Collection...best locations for finger sticks are the 3rd and 4th fingers of the non-dominant hand. Do not use the tip of the finger or the center of the finger...Cleanse selected finger with alcohol pad. Make sure sample site is completely dry. Make a skin puncture just off the center of the finger pad. Wipe away first blood sample and us [sic] second blood sample for testing."</p> <p>a) On 3/11/14 at 11:50 a.m., LN #9 was observed as she performed a BG check for Resident #6. The LN stuck the resident's left thumb with a lancet, wiped away the first drop of blood with an alcohol wipe, then without waiting for the alcohol to dry, the LN collected the second drop of blood on the test strip.</p> <p>Immediately afterward, when asked about the BG technique, LN #9 stated, "Usually I have a cotton ball with me but this time I used the alcohol wipe."</p> <p>b) On 3/12/14 at 11:40 a.m., LN #3 was observed as she performed a BG check for Resident #6. The LN wiped the resident's left 4th finger with an alcohol pad, stuck the finger with a lancet, waited</p>	F 281		

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F 281	Continued From page 12 5-6 seconds, then used the first drop of blood for the BG. Immediately afterward, when asked about the BG technique, LN #3 stated, "I should use the 2nd drop. I know." On 3/14/14 at 4:00 p.m., the Administrator was informed of the issue. No other information was received from the facility regarding the issue. 3. On 3/14/14 at 8:10 a.m., LN #9 was observed as she prepared Lantus insulin 12 units for subcutaneous (sub-q) injection for Resident #15. While still at the medication cart in the medication room, a second LN verified the dose and LN #9 documented in the resident's eMAR that the insulin was administered in the resident's left upper arm. In the resident's room a few minutes later, however, the LN administered the insulin injection into the resident's right upper arm. Before the LN moved from the resident's side, the surveyor asked her in which arm she had given the insulin. The LN looked at the resident's arms then stated, "The right. It should have been the left, that's what I documented." On 3/14/14 at 4:00 p.m., the Administrator was informed of the documentation issue. No other information was received from the facility regarding the issue.	F 281			
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a	F 314	F314 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #4 Care plan was reviewed and revised to include individualized measures to prevent reoccurrence of pressure ulcers. Continued	4-18 2014	

*4/16/14 - 3:00 PM
Talked with DON
& in service included
how to document correction
for site of injection of
Correct documented
J Case*

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F 314	<p>Continued From page 13</p> <p>resident, the facility must ensure that a resident who enters the facility without pressure sores 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 record review and staff interview it was determined the facility failed to ensure measures to prevent the development of an avoidable Stage II pressure ulcer were included in a resident's care plan. This was true for 1 of 6 sample residents (#4) reviewed for pressure ulcer and put the resident at risk for the reoccurring pressure ulcers. Findings included:</p> <p>Resident #4 was admitted to the facility on 10/11/12 with multiple diagnoses which included schizoaffective disorder, chronic airway disorder and renal insufficiency.</p> <p>Resident #4's Significant Change MDS, dated 1/22/14, documented in part: * Extensive assistance needed with 2 or more people for bed mobility, dressing, personal hygiene and toilet use; * Did not have any pressure ulcers.</p> <p>The resident's current care plan, dated 10/11/12 for Impaired Skin Integrity related to chronic skin issues and fragile skin included interventions of: * Daily skin assessment, * Provide first aid as ordered for all skin tears, * Q (every) 2 hour repositioning while in bed,</p>	F 314	<p>How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken: All residents have the potential to be affected by the deficient practice. New Braden Scales will be completed on all residents to determine level of risk. Care plans will be reviewed and revised to include individualized measures to prevent the development of pressure ulcers and to treat pressure ulcers if they develop.</p> <p>What measures will be put in place or what systemic change will you make to ensure that the deficient practice does not recur: Care plans will be reviewed and revised with MDS assessments, changes in condition or if pressure ulcers develop.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice does not recur, i.e., what quality assurance program will be put into place: Administrator and DNS to review care plans weekly x 4, then q 2 weeks x 4, then monthly x 3 for residents who have a change in condition putting them at higher risk for skin breakdown and for any resident who develops pressure ulcers. Audit results reported at Quarterly QA Meetings. Audits to begin 4/14.</p>		

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F 314	<p>Continued From page 14</p> <ul style="list-style-type: none"> * Float heels or place in soft boots to protect heels, * Dress wound on right leg <p>A 1/29/14 Nursing Progress Note (NPN) documented "...observed resident's L (left) coccyx has a 2.0 cm (centimeter) diameter opening with purulent drainage."</p> <p>The temporary Care Plan for Resident #4, dated 1/29/14, documented a Problem of Impaired Skin Integrity and a 3 cm diameter reddened non-blanching area on the right buttock with small dark purple area. The temporary plan did not identify the open area documented in the 1/29/14 NPN. The Intervention section of the temporary Care Plan documented:</p> <ul style="list-style-type: none"> * Observe for changes Q (every) day in appearance. * Clean site as necessary. * Assess for safety issues/concerns. * Remove clutter, unnecessary items from room. * Assess for appropriate safety devices. * Use extra caution when transferring. * Clinic notified. * Encourage resident to lay on side. <p>A Hospice Progress Note, dated 2/3/14 documented, "Her buttocks has [sic] two dark red areas, none are open today."</p> <p>During observations on 3/11/14 at 8:25 a.m., 8:56 a.m., 10:35 a.m., 11:50 a.m., 12:25 p.m. and 4:10 p.m. the resident was in bed on her back with a pressure relieving mattress in place.</p> <p>On 3/13/14 at 2:30 p.m. the MDS Coordinator was asked what interventions the facility had implemented to prevent a reoccurrence of the</p>	F 314	<p><i>Don stated discussed CP revision for Pressure ulcer when 280 was discussed</i></p>	
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F 314	Continued From page 15 pressure ulcer on the coccyx. She responded the resident was to be repositioned every 2 hours. When asked if this was a standard intervention, rather than an one individualized for the resident for prevention of the pressure ulcer, she said, "yes." She acknowledged that the care plan prior to the development of the pressure ulcer included repositioning every 2 hours. The interventions were not revised after the resident developed the pressure ulcer on her coccyx. The Coordinator stated a revision to the care plan could have been to reposition the resident every hour. The Coordinator was informed the temporary Care Plan intervention to have the resident "lay on her side" was not included in the resident's current care plan. The Coordinator agreed the current care plan did not include interventions to prevent the pressure ulcer on the coccyx from reoccurring.	F 314			
F 323 SS=D	On 3/13/14 at 5:00 p.m. the Administrator was informed of the issue. The Administrator stated the facility had placed the resident on a pressure relieving mattress. The Administrator was informed that the pressure relieving mattress was not included in the intervention section on the resident's care plan for Skin Integrity. 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	F323 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #7 Level of supervision provided per policy. 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: No other residents were receiving 1:1 supervision at time of mailing Plan of Correction. Revised Continued	4-18 2014	

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F 323	<p>Continued From page 16</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, record review, and policy review, it was determined the facility failed to provide one to one (1:1) supervision as ordered and care planned for 1 of 2 residents (#7) reviewed for supervision. Failure to consistently implement 1:1 supervision placed Resident #7 at risk for a fall with injury. Findings included:</p> <p>Resident #7 was readmitted to the facility on 2/24/14 with multiple diagnoses which included bipolar I disorder, dementia, epilepsy, and aftercare following surgical intervention of a left hip fracture.</p> <p>The resident's physician's orders included, "1:1 for fall safety," dated 2/24/14.</p> <p>The resident's care plan included the problem, "Potential for falls," on 10/30/13. Interventions included, "Recent fall monitor behaviors for increased agitation, offer toileting Q [every] 2 [hours] and prn [as needed]. Hx [history] of rapid, impulsive ambulation lacks insight and judgement for safety precautions" and "Place 1:1 for safety." Both interventions were dated 2/25/14.</p> <p>On 3/11/14, during the lunch meal in the Red Wing Lounge (also called the lounge, the day room, and the dining room) on 2nd Street, the following was observed: * 12:10 p.m. - Resident #7 and 9 other residents were in the lounge with 3 PTs (Psych Techs, or CNAs), and 1 Social Worker in attendance. Resident #7 was in the first recliner as one would enter the lounge. All of the staff moved about the</p>	F 323	<p>policy will be followed for any other residents requiring 1:1 supervision.</p> <p>What measures will be put in place or what systemic change will you make to ensure that the deficient practice does not recur: Syringa Policy No. 240-02A-400 "Close Monitor (1:1) Guidelines" revised to provide a clearer definition and more specific guidelines regarding physical proximity, risk factors and nature of the relationship which could affect physical proximity to resident (i.e. sudden unexpected changes in resident behavior causing risk to staff). Staff educated at in-service 4/9 regarding policy changes and how they relate to specific resident(s) and different environments (day room).</p> <p>What the corrective action(s) will be monitored to ensure the deficient practice does not recur, i.e., what quality assurance program will be put into place: Social Worker to observe different settings (resident room, day room etc.) 2 x weekly x 8, then weekly x 4 (frequency of audit may change if there are no residents on 1:1 supervision). Audit results reported at Quarterly QA Meeting. Audits to start 4/14.</p>

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F 323	<p>Continued From page 17</p> <p>room as they assisted the residents. None of the staff stayed near Resident #7.</p> <p>* 12:12 p.m. - When asked who was assigned to be the lounge monitor and who was Resident #7's 1:1, PT/CNA #11 said she was both. She stated, "I am [the lounge monitor] when he's [Resident #7] in here."</p> <p>* 12:13 to 12:38 p.m. - PT/CNA #12 sat in a recliner next to Resident #7.</p> <p>* 12:38 p.m. - PT/CNA #12 told Resident #7, "There's your soup," and she walked to the kitchenette window (approximately 20 feet from the resident) to get the meal tray. Once at the kitchenette window, the CNA stated, "No it's not." The CNA took the meal tray to another resident at a table approximately 15 feet away from Resident #7. This left Resident #7 without 1:1 supervision.</p> <p>* 12:39 p.m. - PT/CNA #12 returned to the recliner by Resident #7.</p> <p>On 3/11/14 at 2:10 p.m., PT/CNA #12 was asked about 1:1 supervision for Resident #7. The PT/CNA stated, "He's 1:1 for fall risk." When asked what that meant, the PT/CNA stated, "It's generally supposed to be within arms length." When asked if any staff member was within arms length to the resident before she sat by the resident, the PT/CNA shook her head no and stated, "They have told us [resident's name] 1:1 can also be the day room monitor when [resident's name] is in there." When asked if a 1:1 staff was always within arms length when the resident was in the Red Wing lounge, PT/CNA #12 stated, "No."</p> <p>On 3/11/14 at 4:55 p.m., the Administrator and DNS were asked to provide the policy regarding 1:1 supervision.</p>	F 323			

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F 323	<p>Continued From page 18</p> <p>On 3/12/14 at about 8:45 a.m., the Administrator provided a policy titled "Close Monitor (1:1) Guidelines." The policy included, in part, "Definitions: Close Monitor: Direct one-to-one staff supervision wherein an assigned staff member maintains physical proximity to the patient at all times regardless of patient location. The distance and nature of the relationship to the patient will be dependent upon the clinical needs of the patient." (Note: Only one definition was listed.) "Procedures: ...The nurse or assigned PT [Psych Tech, or CNA] will physically observe the resident, and assess the residents immediate safety needs..."</p> <p>On 3/12/14, during the evening meal in the 2nd Street Red Wing Lounge, the following was observed:</p> <p>* 5:10 to 5:12 p.m. - Resident #7 and 8 other residents were in the room with 1 PT/CNA and 2 PTT (Psych Tech Trainee)/CNAs in attendance. Resident #7 was in the first recliner as one would walk into the room. Another male resident was in the second recliner, approximately 1 1/2 feet away from Resident #7's recliner.</p> <p>* 5:12 to 5:15 p.m. - Two of the staff left the room for 3 minutes which left only PTT/CNA #15 in the room. During that time, PTT/CNA #15 moved about the room as she assisted other residents,</p> <p>* 5:17 to 5:18 p.m. - PTT/CNA #15, who was across the room from Resident #7, was again the only staff in the room. And, at one point, the PTT/CNA's back was to Resident #7 when she removed a container of red liquid from the refrigerator. Then, she served the liquid to other residents.</p> <p>* 5:21 p.m. - PTT/CNA #15 had left the room while PT/CNA #18, PTT/CNA #16, and PTT/CNA #17 all stood at the kitchenette window, with their</p>	F 323		

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F 323	<p>Continued From page 19</p> <p>backs to Resident #7, while they waited for meal trays. Then, the 3 staff served the meal trays to the other residents in the room.</p> <p>* 5:26 to 5:27 p.m. - PTT/CNA #16 was the only staff in the room and he moved about the room as he delivered meal trays to other residents.</p> <p>* 5:27 p.m. - PT/CNA #18 arrived and assisted PTT/CNA #16 to deliver meal trays to other residents.</p> <p>* 5:30 to 5:40 p.m. - PT/CNA #18 assisted the resident in the second recliner while PTT/CNA #16 continued to deliver meals, which included Resident #7's meal.</p> <p>Note: Resident #7 was without 1:1 supervision during the evening meal on 3/12/14.</p> <p>On 3/12/14 at 5:45 p.m., LN #14 was asked about the 1:1 supervision for Resident #7. The LN stated, "He's sort of always on 1:1 because of his history of assaultive behavior. He gets very agitated by the behaviors of other residents, and he fell."</p> <p>On 3/12/14 at 5:50 p.m., LN #14 accompanied the surveyor to the Red Wing lounge. The LN stated, "If the 1:1 is next to [Resident #7] they watch for any signs of agitation. He can't physically move very much, he just had surgery, but he tends to scoot himself forward in the chair." When asked what if the 1:1 was not next to the resident or was the only staff in the room, the LN stated, "There's always more than one [staff] in here." When informed of the multiple observations of only one staff was in the room with Resident #7 and multiple other residents, the LN did not offer a response.</p> <p>On 3/12/14 at 7:00 p.m., the DNS was asked about Resident #7's 1:1 supervision and informed</p>	F 323		

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F 323	Continued From page 20 of the aforementioned observations. The DNS stated, "It [1:1 supervision] could be better defined." And, on 3/13/14 at 12:20 p.m., the Administrator informed the survey team that the DNS had sent an email to all staff, "That there's never been an order for a day room monitor." No other information or documentation was received from the facility which resolved the issue.	F 323			
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. -This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to obtain a re-weigh, recommended by a Registered Dietitian (RD), and twice a month weights, and later weekly weights, as physician ordered and care planned for a resident with significant weight loss. This was true for 1 of 3 residents (#5) reviewed for weight status. The failure created the potential	F 325	F325 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #5 Weights will be obtained according to Physician's orders. 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: All residents have the potential to be affected by the deficient practice. A spread sheet will be developed listing residents and the frequency of weights ordered. Dietician to inform Administrative Assistant to update spread sheet with any changes in physician orders. Licensed nurse will use spread sheet to assign specific staff to obtain scheduled weights. Licensed Nurse will be responsible to ensure compliance. When weight is obtained, date on spread sheet will be yellowed out. Licensed nurse will report at shift change if any weights were not obtained and the reason why so the next shift can keep trying. This process will be continued until weight is obtained. Staff educated at in-service 4/9 regarding changes in process. Continued	4-18 2014	

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F 325	<p>Continued From page 21 for Resident #5 to experience a compromised nutrition status. Findings included:</p> <p>Resident #5 was admitted to the facility 2007, hospitalized 10/28-11/5/13 for pneumonia, and readmitted to the facility 11/5/13, with multiple diagnoses, which included schizoaffective disorder, chronic obstructive pulmonary disease, and congestive heart failure.</p> <p>The resident's physician's orders included the order, "Change Weigh twice a month to Weigh weekly." It was dated 1/8/14.</p> <p>The resident's care plan included the problem, "Potential for Significant wt [weight] loss," dated 11/5/13. The interventions were, "Chopped diet (3/1/13)," and 8 undated interventions, which included, "Weigh weekly. Nursing to Notify RD [and] MD [physician] of significant weight change."</p> <p>NOTE: Refer to F 514, regarding complete and accurate medical records, for details about undated care plan interventions.</p> <p>A Weight Measurement record documented the resident was weighed as follows:</p> <ul style="list-style-type: none"> * twice a month 4/1/13 through 6/15/13; * once in July (7/14/13); * once in August (8/15/13); * twice in September, October, and December 2013; * twice in January (1/12 and 1/19/14); * three times in February (2/3, 2/9, and 2/16/14); and * twice in March (3/3 and 3/10/14). <p>Twice a month weights were not documented as done in July and August 2013; and, no weights</p>	F 325	<p>What measures will be put in place or what systemic change will you make to ensure that the deficient practice does not recur: IDT will review spread sheet at Monday morning meetings, and specific team members will be assigned to assist staff in ensuring weights are obtained.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice does not recur, i.e., what quality assurance program will be put into place: Administrative Assistant to monitor compliance weekly x12, then q 2 weeks x 6. Audit results reported at Quarterly QA Meetings. Audits to begin 4/14.</p> <p><i>Date & staff initials will be documented on spread sheet</i></p>	
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F 325	<p>Continued From page 22</p> <p>were documented for November 2013. No weights were documented between 10/15 and 12/1/13. In addition, after the order and care plan was changed to weekly weights on 1/8/14, weekly weights were not consistently documented as done in January and February, 2014.</p> <p>The Weight Measurement record documented the resident weighed 229.8 pounds on 10/15/13 and 195.4 pounds on 12/1/13. NOTE: This was a significant weight loss of 34.4 pounds, or 14.9 percent, in 1 1/2 months.</p> <p>On 3/13/14 at 4:15 p.m., the RD was asked about the resident's weight loss. The RD stated that since 12/12/12 the resident's nutrition care plan included twice a month weights and she requested a change to weekly weights on 1/8/14, "Because 2 times a month weights were not consistently done." The RD stated the resident was hospitalized 10/28 to 11/5/13, "But, there should have been 2, possibly 3, weights between 10/15 and 12/1/13, and there weren't any." The RD provided her 12/3/13 progress note which documented, "Question accuracy of 34.4 pound wt [weight] loss in 1.5 months. Avg [average] PO [oral] intake of meals is 98% [percent] x [times] 7 days with 2 refusals. One meal refusal was due to resident eating at the Canteen instead. Avg PO intake of HS [bedtime] snack is 100% x 7 days with no refusals. No reported swallowing difficulties over past 7 days. P [plan]: Suggest resident be re-weighed."</p> <p>The RD said she discussed the weight loss issue and need for a re-weigh with the DNS and other nursing staff at a Treatment Team meeting the next day, 12/4/13. The RD said because the re-weigh was not done, she brought the issue up</p>	F 325		
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F 325	Continued From page 23 again at subsequent Treatment Team meetings but the resident was not weighed again until 12/15/13, or 12 days after her initial request. The RD stated that on 12/15/13, the resident's weight was 199.6 pounds, a slight increase of 4.2 pounds (from 195.4 pounds), and she recommended Ensure 3 times a day at that time. The RD stated a healthy BMI (body mass index) was between 19-25 and the resident's BMI was always within or above the healthy range. On 3/13/14 at 6:30 p.m., when the Administrator, Assistant Hospital Administrator, Social Worker (SW), and Physical Therapist were informed of the issue. The SW stated, "We know we have a problem getting weights done." No other information regarding the issue was received from the facility.	F 325			
F 329 SS=D	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic	F 329	F329 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #3 Psychiatrist reviewed drug regimen and provided documentation giving justification for use of 2 anti-depressants. 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: Since all other residents have the potential to be affected by the deficient practice, all other residents receiving duplicate therapy will be identified. Psychiatrist will review drug regimens and provide documentation giving justification for duplicate therapy. Continued	4-18 2014	

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F 329	Continued From page 24 drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure a resident's medication regime was free from duplicate therapy for 1 of 6 sample residents (#3). The practice of prescribing two anti-depressant medications without clinical indication of need placed the resident at risk for unintended side effects including a decline in ADLs or worsening symptoms. Findings included: Federal guidance at F329 states, "...Duplicate therapy' refers to multiple medications of the same pharmacological class/category or any medication therapy that substantially duplicates a particular effect of another medication that the individual is taking...Under these regulations, medication management includes consideration of...III. Dose (including duplicate therapy)...A documented clinical rationale for the benefit of, or necessity for, the dose or for the use of multiple medications from the same pharmacological class...Documentation is necessary to clarify the rationale for & benefits of duplicate therapy & the approach to monitoring for benefits & adverse consequences..." Resident #3 was admitted to the facility on 9/29/11 with diagnoses which included "bipolar severe with psychotic behavior," dementia and	F 329	What measures will be put in place or what systemic change will you make to ensure that the deficient practice does not recur: Pharmacist completes MMR (monthly medication review) and makes a notation when a resident is receiving duplicate therapy. Psychiatrist will review monthly MMRs and provide documentation giving justification for duplicate therapy. How the corrective action(s) will be monitored to ensure the deficient practice does not recur, i.e., what quality assurance program will be put into place: Social Worker will monitor compliance by reviewing MMRs and auditing Psychiatrist justification notes 2 x monthly (during first two weeks of the month) x 6 to ensure compliance. Audit results reported at Quarterly QA Meetings. Audits to start week of 4/7.	

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F 329	Continued From page 25 diabetes. The resident's 1/8/14 quarterly MDS coded cognitively intact, minimal depression, and antidepressant use. Resident #3's 3/14 "ORC current orders" (physician recapitulation orders) contained two orders for antidepressants. - Mirtazapine (Remeron) 30 milligrams (mg) at bedtime for depression, anxiety and insomnia with a start date of 2/19/14. - Fluoxetine (Prozac) 60 mg every morning for depression with a start date of 1/17/14. The resident's medical record did not contain clinical rationale from the physician for the benefit of the two antidepressants. On 3/13/14 at 2:20 p.m., the surveyor informed the MDS Coordinator of the antidepressant duplicate therapy. On 3/13/14 at 6:15 the Administrator and Social Worker were informed of the concern. The facility provided no further information.	F 329			
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it -	F 441	F441 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: BG checks will be administered by Licensed Nurses per policy and with the implementation of infection control measures for residents # 11, 6, 2, 12 Continued	4-18 2014	

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F 441	<p>Continued From page 26</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and policy review, it was determined the facility failed to ensure the implementation of good infection measures related to: *Hand hygiene after providing care to residents; and *Glucometer cleaning between resident uses and proper handling of inanimate objects related to blood glucose (BG) checks.</p>	F 441	<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 receiving BG checks, and all other residents receiving care because of poor hand hygiene have the potential to be affected by the deficient practice. Licensed staff educated and demonstrated competency at in-service 4/9 regarding BG checks including proper hand hygiene, cleaning of glucometer between residents, and proper handling of inanimate objects (blue caddy, sharps container, protective barriers etc.). This process used to correct deficiencies cited for residents #11, 6, 2, and 12.</p> <p>Residents #6, 2 Infection Control educations on proper hand hygiene provided to all staff through computer module. Additionally, proper hand hygiene was reviewed at in-service on 4/9,</p> <p>What measures will be put into place or what systemic change will you make to ensure that the deficient practice does not recur: Hand Sanitizer Dispensers were placed at the entrance inside each resident's room, so staff can sanitize hands upon entering and before leaving a resident's room.</p> <p>Continued</p>	
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F 441	<p>Continued From page 27</p> <p>This was true for 1 of 6 sample residents (#6); and, 4 of 4 residents (#s 2, 6, 11, 12) observed during BG checks. These practices created the potential for cross contamination of germs and placed residents at increased risk for the development and spread of infections. Findings included:</p> <p>1. On 3/11/14 at 12:15 p.m., LN #9 was observed as she performed a BG check for Resident #11 at the desk in the hallway outside the 1st Street Lounge. After the BG check, the LN removed her right hand glove and placed it in the palm of her left hand behind the glucometer in her still gloved left hand. The LN then walked down the hallway to the stairwell door, reached in her pocket with her unclean right hand, removed a key and unlocked the door, returned the key to her pocket, walked up the stairs, opened the door to 2nd Street with her right hand, walked to the 2nd Street med room, reached in her pocket with her right hand, removed a key and unlocked the med room door, and returned the key to her pocket. In the med room, the LN disposed of the right hand glove and placed the used glucometer on top of the countertop, without use of any type of barrier. Then, the LN grasped a container of sanitizing wipes with her still gloved left hand, opened the lid, and removed a wipe with her right hand. The LN picked up the glucometer with her gloved left hand, cleaned it with a wipe in her right hand, then placed the glucometer in the second drawer from the top on the left side of the med cart. After that, the LN removed the left hand glove and sanitized her hands.</p> <p>On 3/13/14 at 2:30 p.m., the Infection Control Nurse (ICN) was informed of infection control issues.</p>	F 441	<p>How the corrective action(s) will be monitored to ensure the deficient practice does not recur, i.e., what quality assurance program will be put into place: DNS to monitor compliance by observing BG checks 2 x weekly x 4, then 1 x weekly x 4, then monthly x 4. Additionally DNS to complete hand hygiene audits 2 x weekly x 4, then 1 x weekly x 4, then monthly x 4. Audits to be reported at Quarterly QA/PI Meetings. Audits to start 4/14.</p>		

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

PRINTED: 03/25/2014
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 03/14/2014
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)
F 441	<p>Continued From page 28</p> <p>2. On 3/12/14, LN #3 was observed as she performed blood glucose (BG) checks as follows:</p> <p>a) 11:40 a.m. - The LN checked Resident #6's BG. However, the LN did not clean the glucometer before she left the resident's room and returned to the 2nd Street med room. In the med room, the LN placed the uncleaned glucometer on the counter, without use of any type of barrier, while she entered the BG results in the computer and prepared for the next BG. The LN did not clean the glucometer before she left the med room and went to Resident #2's room.</p> <p>b) 11:45 a.m. - In Resident #2's room, the LN placed the uncleaned glucometer on the bed next to the pillow under the resident's head, without use of any type of barrier, then she performed the BG check. After the BG check, the LN placed the uncleaned glucometer on the side of a blue caddy that contained uncovered cotton balls then she removed her gloves and left the room. The LN did not perform any hand hygiene until she returned to the med room. Then she asked a CNA to bring Resident #12 to the med room for his BG check.</p> <p>c) 11:50 a.m. - A CNA brought Resident #12 in his wheelchair (w/c) to the med room doorway. The LN was about to check the resident's BG when she was asked if the glucometer had been cleaned. The LN stated, "Oh, I forgot. Thank you." and she immediately cleaned the glucometer with a sanitizer wipe. While the glucometer dried, the LN continued preparations for the BG check. She placed the blue caddy on the floor next to the resident's w/c and removed a small sharps container from the caddy which she placed on the floor next to the caddy. Moments later, the LN picked up the caddy and put it in the seat of the office chair in the room. After that, the</p>	F 441	

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F 441	<p>Continued From page 29</p> <p>LN stuck the resident's finger with a lancet, dropped the lancet in the sharps container on the floor, and completed the BG check. Then, the LN placed the sharps container and the glucometer on the counter next to the sink, without use of any type of barrier, washed her hands, applied new gloves, sanitized the glucometer, and put the sharps container back in the blue caddy.</p> <p>On 3/12/14 at about 12:30 p.m., LN #3 asked what the infection control issues were. She was informed the glucometer was not cleaned between residents, contents in the blue caddy were contaminated when the uncleaned glucometer was placed on top of them, the med room counter was contaminated when the uncleaned glucometer and sharps container, which had been on the floor, were placed on it, a resident's bed was contaminated when the uncleaned glucometer was placed on it, and no hand hygiene after glove removal following direct contact with residents. The LN acknowledged this with a head nod and said, "Thank you, I appreciate that."</p> <p>On 3/13/14 at 2:30 p.m., the ICN was informed of infection control issues.</p> <p>3. a) On 3/12/14 at 12:15 p.m., LN #14 was observed as she removed Resident #6's socks and tennis shoes, assessed the resident's feet, then reapplied the socks and tennis shoes while the resident sat in his wheelchair (w/c) in his room. After that, the LN removed her gloves and placed them in her left hand. However, the LN did not dispose of the used gloves or perform hand hygiene before she left the resident's room. With the used gloves still in her left hand, the LN walked to the Red Wing Lounge, on the other end</p>	F 441			

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F 441	<p>Continued From page 30 of the unit, and asked PT/CNA #2 to assist her to transfer Resident #6.</p> <p>b) On 3/12/14 at 12:25 p.m., LN #14 and PT/CNA #2 were observed as they entered Resident #6's room. The LN disposed of the used gloves and washed her hands. Then, she and PT/CNA transferred the resident from the w/c to the bed using a Hoyer type mechanical lift. After that, the two staff pulled the resident's pants down, repositioned the resident onto his right side, and unfastened the incontinence brief. The LN assessed the resident's left hip then assisted the PT/CNA to reconnect the incontinence brief and reposition the resident until he was comfortable. Both staff removed and disposed of their gloves. However, neither of them performed hand hygiene before they left the resident's room.</p> <p>Immediately afterward, as LN #14 and PT/CNA #2 walked down the hallway they were asked about hand hygiene. The LN stated, "We like to do it [hand washing] out here." The LN pointed to a sink in a short hallway between the med room and room 242. When asked what they would have done had they have found a resident on the floor in the hallway when they left Resident #6's room, PT/CNA #2 stated, "I see what you mean."</p> <p>On 3/13/14 at 2:30 p.m., the ICN was informed of infection control issues.</p> <p>On 3/14/14 at 1:50 p.m., the ICN informed the survey team she had sent out an email to all facility staff about the infection control issues.</p> <p>The facility did not provide any other information regarding the infection control issues.</p>	F 441			

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F 514 F 514 SS=E	<p>Continued From page 31</p> <p>483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to maintain clinical records on each resident in accordance with accepted professional standards and practices to ensure resident care plans were complete and accurate. This was true for 3 of 9 (#s 1, 2, and 5) sampled residents. This deficient practice created the potential for the residents' care to be based on incomplete or inaccurate information and increased the risk for complications due to inappropriate care or interventions. Findings included:</p> <p>1. Resident #2 was admitted to the facility on 3/7/10.</p> <p>The resident's medical record documented the resident had fallen on 11/30/13, 12/15/13 and 12/28/13.</p>	F 514 F 514	<p>F514</p> <p>What corrective action(s) will be Accomplished for those residents found to have been affected by the deficient practice: Residents #1,2,5 Care plans will be reviewed and revised to ensure that they are complete and accurate with start dates and discontinued dates for interventions.</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. All care plans will be reviewed and revised to ensure accuracy and completeness with intervention dates.</p> <p>What measures will be put into place or what systemic change will you make to ensure that the deficient practice does not recur: Care plans will be reviewed and revised as needed with MDS assessments to ensure compliance</p> <p>Continued</p>	4-18 2014

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F 514	<p>Continued From page 32</p> <p>Resident #2's 1/10/12 current care plan (in the resident's record on 3/10/14) documented under the focus area of "Risk for Falls":</p> <ul style="list-style-type: none"> - Encourage resident to use call light and to ask for assistance as needed; - Maintain a clutter free room and clear floor; - Offer resident his 2 wheeled walker for stability. Prompt (resident name) for proper use of walker as needed; - Mattress between bed and wall for safety precautions since resident has a history of leaning to the edge of the bed; - Tab alarm when in bed. <p>NOTE: There was no date of implementation for any of the above interventions.</p> <p>The surveyor requested the Care Plan in place when the resident fell on 11/30/13. The facility provided two additional Care Plans (from the closed record), both dated 1/10/12. One of the additional Care Plans included a hand written statement signed by LN #9 for an intervention for "15 minute fall safety checks" dated 1/29/14. This intervention was not in the current care plan; however, it should have been. NOTE: Refer to F280 for additional information regarding this.</p> <p>The second Care Plan included the following hand written interventions:</p> <p>12/15/13- "Close monitor 1:1 (one to one) and 2 person assist between wheelchair and bed." It was listed as discontinued on 12/20/13.</p> <p>12/17/13- "Please use tab alarm while in bed." Discontinued on 12/23/13</p> <p>12/23/13- "15 min[ute] safety checks, Place pressure alarm to bed to assist in monitoring Res[ident] movements."</p>	F 514	<p>How the corrective action(s) will be monitored to ensure the deficient practice does not recur, i.e., what quality assurance program will be put into place: Administrator and DNS will review care plans weekly x 4, then q 2 weeks x 4, then monthly x 3 to ensure accuracy and completeness. Audit results to be reported at Quarterly QA/PI Meetings. Audit to start 4/14.</p>	

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F 514	<p>Continued From page 33</p> <p>1/6/14 - "1:1 close monitor -Place on 15 minutes safety checks. Tab alarm on bed and wheelchair. Discontinue pressure alarm in bed."</p> <p>NOTE: The only interventions with a start date or a discontinue date were the interventions which were hand written. Additionally current interventions in place, such as 15 minute safety checks, were not included in the interventions on the Care Plan in place on 3/10/14.</p> <p>On 3/13/14 at 2:30 p.m. the MDS Coordinator was asked about the interventions of 15 minute safety checks. The Coordinator stated she was not aware the handwritten interventions needed to be transferred from the previous care plan to the current care plan. The Coordinator was also informed the date of implementation needed to be documented on the care plan. Additionally, any intervention which was discontinued needed to have the date it was discontinued.</p> <p>2. Resident #1 was readmitted to the facility in October 2013 .</p> <p>The resident's care plan documented multiple problem areas and each problem area listed interventions. However, the date the interventions were implemented was not consistently documented, as follows:</p> <ul style="list-style-type: none"> * ADL self care deficit, dated 10/10/13 - 14 of 16 interventions not dated; * Treatment refusal, dated 10/10/13 - 2 of 10 interventions not dated; * Potential for pain, dated 12/3/13 - 3 of 3 interventions not dated; * Impaired skin integrity, dated 10/10/13 - 4 of 7 interventions not dated; 	F 514			

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NAME OF PROVIDER OR SUPPLIER SYRINGA CHALET NURSING FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 700 EAST ALICE STREET BLACKFOOT, ID 83221
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F 514	<p>Continued From page 34</p> <p>* Potential for falls, dated 10/10/13 - 2 or 4 interventions not dated; and</p> <p>* Alteration in nutrition, dated 10/10/13 - 10 of 10 interventions not dated.</p> <p>Note: The resident's care plan contained similar findings for other problem area interventions.</p> <p>On 3/13/14 at 2:30 p.m. the MDS Coordinator was asked about undated care plan interventions. The Coordinator indicated she was not aware the implementation dates needed to be included.</p> <p>3. Resident #5 was admitted to the facility 2007, and readmitted to the facility 11/5/13.</p> <p>The resident's care plan, dated 11/5/13, documented multiple problem areas and each problem area listed interventions. However, the date the interventions were implemented was not consistently documented, as follows:</p> <p>* ADL self care deficit - 6 of 11 interventions not dated;</p> <p>* Potential for falls - 4 of 5 interventions not dated;</p> <p>* Potential for altered skin integrity - 7 of 7 interventions not dated; and,</p> <p>* Potential for Significant weight loss - 8 of 9 interventions not dated.</p> <p>Note: The resident's care plan contained similar findings for other problem area interventions.</p> <p>On 3/13/14 at 2:30 p.m. the MDS Coordinator was asked about undated care plan interventions. The Coordinator indicated she was not aware the implementation dates needed to be included.</p> <p>On 3/13/14 at 6:15 p.m., the Administrator and Assistant Hospital Administrator were informed of the issue. The facility did not provide any other</p>	F 514		
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F 514	Continued From page 35 information about the issue.	F 514		
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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 03/14/2014
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C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>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.</p> <p>The following deficiencies were cited during the State licensure survey of your facility.</p> <p>The surveyors conducting the survey were: Linda Kelly, RN; and, Sherri Case, LSW, QMRP.</p> <p>The survey team entered the facility on 3/10/14 and exited the facility on 3/14/14.</p>	C 000		
C 125	<p>02.100,03,c,ix Treated with Respect/Dignity</p> <p>ix. Is treated with consideration, respect and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;</p> <p>This Rule is not met as evidenced by: Refer to F 241 as it related to the use of clothing protectors rather than napkins during meal service.</p>	C 125	See Response to F241	4-18 2014
C 393	<p>02.120,04,b Staff Calling System at Each Bed/Room</p> <p>b. A staff calling system shall be installed at each patient/resident bed and in each patient/resident toilet, bath and shower room. The staff call in the toilet, bath or shower room shall be an emergency call. All calls shall register at the staff station and shall actuate a visible signal in the corridor at the</p>	C 393	See Response to F246	4-18 2014

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Tamara Sellins

Administrator

4/7/14

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 03/14/2014
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C 393	Continued From page 1 patient's/resident's door. The activating mechanism within the patient's/resident's sleeping room shall be so located as to be readily accessible to the patient/resident at all times. This Rule is not met as evidenced by: Refer to F 246 as it related to resident accessibility to call lights.	C 393		
C 644	02.150,01,a,i Handwashing Techniques a. Methods of maintaining sanitary conditions in the facility such as: i. Handwashing techniques. This Rule is not met as evidenced by: Refer to F 441 as it related to hand hygiene.	C 644	See Response to F441	4-18 2014
C 745	02.200,01,c Develop/Maintain Goals/Objectives c. Developing and/or maintaining goals and objectives of nursing service, standards of nursing practice, and nursing policy and procedures manuals; This Rule is not met as evidenced by: Refer to F 281 as it related to standards of practice.	C 745	See Response to F281	4-18 2014
C 782	02.200,03,a,iv Reviewed and Revised 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: Please refer to F-280 as it relates to review and	C 782	See Response to F280	4-18 2014

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C 782	Continued From page 2 revision of Care Plans	C 782		
C 788	02.200,03,b,iv Medications, Diet, Treatments as Ordered iv. Delivery of medications, diet and treatments as ordered by the attending physician, dentist or nurse practitioner; This Rule is not met as evidenced by: Refer to F 325 as it related to physician ordered weights.	C 788	See Response to F325	4-18 2014
C 789	02.200,03,b,v Prevention of Decubitus 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 related to pressure ulcers.	C 789	See Response to F314	4-18 2014
C 790	02.200,03,b,vi Protection from Injury/Accidents vi. Protection from accident or injury; This Rule is not met as evidenced by: Refer to F 323 as it related to 1:1 supervision and fall care plan revisions.	C 790	See Response to F323	4-18 2014
C 846	02.201,02,t Equipment Cleaned After Each Use t. Equipment for the administration of medications shall be thoroughly cleaned and suitably stored after each	C 846	See Response to F441	4-18 2014

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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 03/14/2014
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NAME OF PROVIDER OR SUPPLIER SYRINGA CHALET NURSING FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 700 EAST ALICE STREET BLACKFOOT, ID 83221
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 846	Continued From page 3 use. This Rule is not met as evidenced by: Refer to F 441 as it related to multi-resident use glucomemters for blood glucose testing.	C 846		
C 881	02.203,02 INDIVIDUAL MEDICAL RECORD 02. Individual Medical Record. An individual medical record shall be maintained for each admission with all entries kept current, dated and signed. All records shall be either typewritten or recorded legibly in ink, and shall contain the following: This Rule is not met as evidenced by: Refer to F 514 as it related to undated care plan interventions.	C 881	See Response to F514	4-18 2014