



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 4094**

July 31, 2014

Tamara Gillins, Administrator  
Syringa Chalet Nursing Facility  
PO Box 400  
Blackfoot, ID 83221-0400

Provider #: 135111

**RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER  
LETTER**

Dear Ms. Gillins:

On **July 21, 2014**, a Facility Fire Safety and Construction 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 Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency 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. 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. **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 2). After each deficiency has been answered and dated, the administrator should sign both Statement of Deficiencies and Plan of Correction, Form CMS-2567 and State Form, in the spaces provided and return the originals to this

**FILE COPY**

Tamara Gillins, Administrator  
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office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **August 13, 2014**. Failure to submit an acceptable PoC by **August 13, 2014**, may result in the imposition of civil monetary penalties by **September 2, 2014**.

Your PoC must contain the following:

- 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 into place or what systemic changes 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; and,
- Include dates when corrective action will be completed.
- 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.

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 **August 25, 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 **August 25, 2014**. A change in the seriousness of the deficiencies on **August 25, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **August 25, 2014**, includes the following:

Denial of payment for new admissions effective **October 21, 2014**.  
42 CFR §488.417(a)

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July 31, 2014

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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 **January 21, 2015**, 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 Mark P. Grimes, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, 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. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **July 21, 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 non-compliance at the time of the revisit, if appropriate.

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

<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:

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July 31, 2014  
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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 **August 13, 2014**. If your request for informal dispute resolution is received after **August 13, 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,

A handwritten signature in black ink, appearing to read 'M P Grimes', with a long horizontal flourish extending to the right.

Mark P. Grimes, Supervisor  
Facility Fire Safety and Construction

MPG/lj  
Enclosures

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

PRINTED: 08/12/2014  
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 02  B. WING _____	(X3) DATE SURVEY COMPLETED  07/21/2014
NAME OF PROVIDER OR SUPPLIER  SYRINGA CHALET NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 700 EAST ALICE STREET (83221-4925) 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
K 000	INITIAL COMMENTS  The facility is a four story type II (222) fire resistive building. Residents are currently being housed on floors two and three, the ground floor is ancillary services only. A complete fire sprinkler system was installed in June of 2012. The building was last renovated in 1996. There are multiple exits to grade and the facility fire alarm is monitored off site and at the on campus central security building. The building is licensed for 29 SNF/NF beds.  The following deficiencies were cited during the annual fire/life safety survey conducted on July 21, 2014. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.  The Survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	K 000		
K 012 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the smoke resistive properties of smoke barrier ceilings. Failure to ensure that smoke barriers resist the passage of smoke would allow smoke and dangerous gases to pass	K 012		

**RECEIVED**  
AUG 13 2014  
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Jamara Hellins, Administrator* TITLE \_\_\_\_\_ (X6) DATE 8-12-14

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135111	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02  B. WING _____		(X3) DATE SURVEY COMPLETED  07/21/2014
NAME OF PROVIDER OR SUPPLIER  SYRINGA CHALET NURSING FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 700 EAST ALICE STREET (83221-4525) BLACKFOOT, ID 83221		
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K 012	<p>Continued From page 1</p> <p>freely between smoke compartments affecting egress. This deficient practice affected 21 residents, staff and visitors in 4 of 8 smoke compartments on the date of the survey. The facility is licensed for 29 SNF/NF beds and had a census of 23 on the day of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour conducted on July 21, 2014 from 1:15 PM to 3:45 PM, observation of the mechanical closet located in the ground floor Chapel, revealed electrical conduits passing through the mechanical closet were not sealed as they entered the soffit inside the Chapel. Further observation of this soffit revealed a gap of approximately 1/2 inch wide, six inches long. When illuminated, light was clearly visible from the interior of the mechanical closet into the Chapel area. During interview, the Maintenance Supervisor indicated he was unaware the grid ceiling was a smoke barrier component.</p> <p>2) During the facility tour conducted on July 21, 2014 from 1:15 PM to 3:45 PM, continuing observation of the soffits revealed gaps between the tilework and supporting frame varying from 1/2 to one inch wide and three inches to six inches long demonstrating inconsistent maintenance of the smoke barrier requiring no further observation.</p> <p>Actual NFPA standard:</p> <p>19.1.6.4 Each exterior wall of frame construction and all interior stud partitions shall be firestopped to cut off all concealed draft openings, both horizontal and vertical, between any cellar or basement and</p>	K 012	<p>Work order 8138 was issued to the Maintenance Department. Ceiling tiles were replaced and resistive clips installed to ensure the ceiling tiles remain in place.</p> <p>Maintenance Department checked all ceilings at Syringa to ensure ceiling tiles were securely in place.</p> <p>Maintenance Department will complete weekly checks for 3 months, and then monthly thereafter on an on-going basis to verify the tiles remain in place.</p> <p>Administrator to ensure checks are completed. Results reported at Quarterly QA/PI Meeting.</p>	7-31-14

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

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K 012  K 020 SS=E	<p>Continued From page 2</p> <p>the first floor. Such firestopping shall consist of wood not less than 2 in. (5 cm) (nominal) thick or shall be of noncombustible material.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1.</p> <p>This STANDARD is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure that elevator smoke doors would close when activated. Failure to ensure that smoke doors close when activated would allow smoke and dangerous gases to pass freely between smoke compartments. This deficient practice affected 4 residents, staff and visitors in 2 of 8 smoke compartments on the date of the survey. The facility is licensed for 29 beds and had a census of 23 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on July 21, 2014 from 3:15 PM to 4:30 PM, observation and operational testing of the elevator smoke doors on the first and second floors' north side revealed these doors would not close when activated leaving approximately a 1/2 to 3/4 inch gap between the door edge and the frame. When asked if he was aware these doors were not completely closing, the Maintenance Director</p>	K 012  K 020		

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K 020	Continued From page 3 stated he was not.  Actual NFPA standard:  19.3 PROTECTION 19.3.1 Protection of Vertical Openings. 19.3.1.1 Any vertical opening shall be enclosed or protected in accordance with 8.2.5. Where enclosure is provided, the construction shall have not less than a 1-hour fire resistance rating. Exception No. 1: Unprotected vertical openings in accordance with 8.2.5.8 shall be permitted. Exception No. 2: Exception No. 1 to 8.2.5.6(1) shall not apply to patient sleeping and treatment rooms. Exception No. 3: Multilevel patient sleeping areas in psychiatric facilities shall be permitted without enclosure protection between levels, provided that all the following conditions are met: (a) The entire normally occupied area, including all communicating floor levels, is sufficiently open and unobstructed so that a fire or other dangerous condition in any part is obvious to the occupants or supervisory personnel in the area. (b) Egress capacity is sufficient to provide simultaneously for all the occupants of all communicating levels and areas, with all communicating levels in the same fire area being considered as a single floor area for purposes of determination of required egress capacity. (c) The height between the highest and lowest finished floor levels shall not exceed 13 ft (4 m); the number of levels shall not be restricted. Exception No. 4: Unprotected openings in accordance with 8.2.5.5 shall not be permitted. Exception No. 5: Where a full enclosure of a stairway that is not a required exit is impracticable, the required enclosure shall be	K 020	Work order 8139 was issued to the Maintenance Department. All elevator fire doors were lubricated and tested and found to operate properly.  Maintenance Department will conduct tests weekly for 3 months, and then monthly thereafter on an on-going basis per the usual Preventative Maintenance work order to ensure the proper functioning of the elevator doors.  Administrator to ensure checks are completed. Results reported at Quarterly QA/PI Meeting.	7-22-14	

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NAME OF PROVIDER OR SUPPLIER  SYRINGA CHALET NURSING FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 700 EAST ALICE STREET (83221-4825) BLACKFOOT, ID 83221		
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K 020	Continued From page 4 permitted to be limited to that necessary to prevent a fire originating in any story from spreading to any other story.	K 020		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135111	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  07/21/2014
NAME OF PROVIDER OR SUPPLIER  SYRINGA CHALET NURSING FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 400 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 facility is a four story type II (222) fire resistive building. Residents are currently being housed on floors two and three, the ground floor is ancillary services only. A complete fire sprinkler system was installed in June of 2012. The building was last renovated in 1996. There are multiple exits to grade and the facility fire alarm is monitored off site and at the on campus central security building. The building is licensed for 29 SNF/NF beds.  The following deficiencies were cited during the annual fire/life safety survey conducted on July 21, 2014. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, in accordance with 42 CFR 483.70 and IDAPA 16.03.02 Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities.  The Survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	C 000		
C 226	02.106 FIRE AND LIFE SAFETY  106. FIRE AND LIFE SAFETY. Buildings on the premises used as facilities shall meet all the requirements of local, state and national codes concerning fire and life safety standards that are applicable to health care facilities.	C 226		

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AUG 13 2014  
**FACILITY STANDARDS**

Idaho form

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

*Samara Gillins*

TITLE

*Administrator*

(X6) DATE

*8-12-2014*

Bureau of Facility Standards

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C 226	Continued From Page 1  This Rule is not met as evidenced by: Please refer to "K" tags listed on CMS 2567  K012 Smoke barrier continuity K020 Smoke barrier doors	C 226	See K012  See K020	7-31-14  7-22-14