IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK– ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
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

December 28, 2016

Tamara Gillins, Administrator
Syringa Chalet Nursing Facility
PO Box 400
Blackfoot, ID 83221-4925

Provider #: 135111

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

Dear Ms. Gillins:

On **December 20, 2016**, 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. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. 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 the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office. If a State Form with deficiencies was issued, it should be signed, dated and returned along with the CMS-2567 Form.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **January 10, 2017**. Failure to submit an acceptable PoC by **January 10, 2017**, may result in the imposition of civil monetary penalties by **January 30, 2017**.

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. If a State Form was issued as well, it should also be signed, dated and returned.

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 **January 24, 2017**, (Opportunity to Correct). Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **January 24, 2017**. A change in the seriousness of the deficiencies on **January 24, 2017**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **January 24, 2017**, includes the following:

Denial of payment for new admissions effective **March 20, 2017**.
42 CFR §488.417(a)

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying 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 **June 20, 2017**, if substantial compliance is not achieved by that time.

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

If you believe these deficiencies have been corrected, you may contact Nate Elkins, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, option 3; 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 **December 20, 2016**, 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:

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 **January 10, 2017**. If your request for informal dispute resolution is received after **January 10, 2017**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626, option 3.

Sincerely,

Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj

Enclosures

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

PRINTED: 01/18/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	135111		12/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYRINGA CHALET NURSING FACILITY	700 EAST ALICE STREET BLACKFOOT, ID 83221

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The facility is a four story type II (222) fire resistive building. Residents are currently being housed on the first and second level, the ground floor is ancillary services only and the fourth floor currently houses minimal staff. 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 December 20, 2016. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70. The Survey was conducted by: Linda Chaney Health Facility Surveyor Facility Fire Safety and Construction	K 000		
K 111 SS=D	NFPA 101 Building Rehabilitation Building Rehabilitation Repair, Renovation, Modification, or Reconstruction Any building undergoing repair, renovation, modification, or reconstruction complies with both of the following: * Requirements of Chapter 18 and 19 * Requirements of the applicable Sections 43.3, 43.4, 43.5, and 43.6 18.1.1.4.3, 19.1.1.4.3, 43.1.2.1 Change of Use or Change of Occupancy	K 111	**K111 NFPA 101 Building Rehabilitation** Self-closing mechanisms will be installed on all doors identified during the survey. Maintenance Staff will check doors every 2 months on an on-going basis with their routine facility safety rounds to ensure the doors function properly. Results reported at Quarterly QA Meetings.	1/23/17

JAN 23 2017
FACILITY

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tamara Gullins, DHA, LCSW
TITLE: Administrator 1/23/17
(X6) DATE: 01/09/2017

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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K 111	Continued From page 1 Any building undergoing change of use or change of occupancy classification complies with the requirements of Section 43.7, unless permitted by 18.1.1.4.2 or 19.1.1.4.2 18.1.1.4.2 (4.6.7 and 4.6.11), 19.1.1.4.2 (4.6.7 and 4.6.11), 43.1.2.2 (43.7) Additions Any building undergoing an addition shall comply with the requirements of Section 43.8. If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a 2-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors with at least a 1-1/2-hour fire resistance rating. Additions comply with the requirements of Section 43.8. 18.1.1.4.1 (4.6.7 and 4.6.11), 18.1.1.4.1.1 (8.3), 18.1.1.4.1.2, 18.1.1.4.1.3, 19.1.1.4.1 (4.6.7 and 4.6.11), 19.1.1.4.1.1 (8.3), 19.1.1.4.1.2, 19.1.1.4.1.3, 43.1.2.3(43.8) This STANDARD is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to meet the requirements for change of use. Failure to comply with the provisions for change of use in the facility could create a higher degree of hazard contents that are likely to burn with extreme rapidity. This deficient practice affected staff and visitors on the date of the survey. The facility is licensed for 29 SNF/NF beds and had a census of 28 on the day of the survey. Findings include: During the facility tour on December 20, 2016 from approximately 9:00 AM to 12:00 PM observation and operational testing of the doors	K 111		

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K 111	Continued From page 2 to rooms 301, 302, 304, 318, 320, 322, 324, 326, 327, 340, 342, 344, and 346 on the fourth floor revealed the doors were not self-closing or automatic closing. Further observation revealed the rooms were converted to storage rooms. When asked, the Support Services Director stated the facility was not aware the doors were required to self-close. Actual NFPA standard: NFPA 101 43.7.1.2 A change of use that does not involve a change of occupancy classification but that creates a hazardous area shall comply with one of the following: (1) The change of use shall comply with the requirements applicable to the new use in accordance with the applicable occupancy chapter for new construction. (2) For existing health care occupancies protected throughout by an approved, supervised automatic sprinkler system in accordance with 9.7.1.1(1), where a change in use of a room or space not exceeding 250 ft2 (23.2 m2) results in a room or space that is described by 19.3.2.1.5(7), the requirements for new construction shall not apply, provided that the enclosure meets the requirements of 19.3.2.1.2 through 19.3.2.1.4. 19.3.2.1.3 The doors shall be self-closing or automatic-closing.	K 111		

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K 222 SS=F	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected	K 222	**K222 NFPA 101 Egress Doors** On 1/4/2017, a list identifying resident-specific psychiatric and/or cognitive diagnosis was sent to [redacted] and [redacted]. Upon further conversation between SCNF Administrator, [redacted] and [redacted] that day, it was determined that Syringa Chalet Nursing Facility met the criteria for the Egress Doors to be locked due to the clinical/security needs of the residents. However, in further conversation with [redacted] a [redacted] on 1/18/17, the doors at the ends of the hallway on Hoover need to be unlocked. The doors were unlocked on 1/18/2017 with signage posted on each door alerting staff to keep these doors unlocked. Maintenance Staff will check doors every 2 months on an on-going basis with their routine facility safety rounds to ensure doors remain unlocked. Results reported at Quarterly QA Meetings.	1/18/17

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K 222	Continued From page 4 throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to maintain the immediate means of egress. Failure to maintain the immediate means of egress could prevent occupants ability to safely evacuate in an emergency. This deficient practice affected staff and visitors on the date of the survey. The facility is licensed for 29 SNF/NF beds and had a census of 28 on the day of the survey. During the facility tour on December 20, 2016 from approximately 9:00 AM to 12:00 PM, observation and operational testing revealed all exit doors on every floor were locked, requiring a key to open the doors. Only the main entrance door that led from the stairwell to the parking lot was on a delayed egress mechanism. When asked, the Support Services Director, Assistant Director of Nursing and other staff stated all staff	K 222		

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K 222	Continued From page 5 had a key that would open the exit egress doors and the facility was unaware that locking the doors was not allowed. Actual NFPA standard: 7.2.1.5 Locks, Latches, and Alarm Devices. 7.2.1.5.1 Door leaves shall be arranged to be opened readily from the egress side whenever the building is occupied. 7.2.1.5.3 Locks, if provided, shall not require the use of a key, a tool, or special knowledge or effort for operation from the egress side.	K 222		
K 363 SS=E	NFPA 101 Corridor - Doors Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates	K 363	**K363 NFPA 101 Corridor – Doors** Upon receipt of materials which have been ordered, the doors entering rooms 201, 204, 247 and 249 will be repaired to resist the passage of smoke. Maintenance Staff will check all doors every 2 months on an on-going basis with their routine facility safety rounds to ensure compliance with Regulations. Results reported at Quarterly QA Meetings.	1/23/17

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K 363	Continued From page 6 of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is not met as evidenced by: Based on observation, operational testing, and interview, the facility failed to maintain doors that protect corridor openings. Failure to maintain corridor doors could allow smoke and dangerous gases to pass freely, preventing defend in place. This deficient practice has affected 12 residents, staff, and visitors on the date of survey. The facility is licensed for 29 SNF/NF beds with a census of 28 on the day of survey. Findings include: During the facility tour on December 20, 2016 from approximately 9:00 AM to 12:00 PM, observation and operational testing of the following resident room doors revealed an approximately 1/4" gap at the top corner of the door between the leading edge of the door and the door frame which would not resist the passage of smoke. - Room 201 - Room 204 - Room 247 - Room 249	K 363		

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K 363	Continued From page 7 When asked, the Support Services Director stated the facility was unaware of the door gaps. Actual NFPA Standards: 19.3.6.3* Corridor Doors. 19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be doors constructed to resist the passage of smoke and shall be constructed of materials such as the following: (1) 13/4 in. (44 mm) thick, solid-bonded core wood (2) Material that resists fire for a minimum of 20 minutes	K 363		
K 916 SS=F	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the EES (Essential Electrical System) was installed in accordance with NFPA 99. Failure to provide an operational alarm annunciator for the EES could hinder early notification of equipment failures, leaving the	K 916	**K916 NFPA 101 Electrical Systems—Alarm Annunciator** The electrical problems related to the alarm annunciator have been identified. We are working to replace the faulty parts in the circuit board and if that is unsuccessful will replace the circuit board. To ensure the annunciator remains in proper working order, Maintenance Staff will check the annunciator monthly with the generator checks. Results reported at Quarterly QA Meetings	1/23/17

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K 916	Continued From page 8 facility without emergency power during an outage. This deficient practice affected 28 residents, staff and visitors on the date of the survey. The facility is licensed for 29 SNF/NF beds and had a census of 28 on the date of the survey. Findings include: During the facility tour on December 20, 2016 from approximately 9:00 AM to 12:00 PM, observation of the generator annunciator for the EES revealed that it was not operational. When asked, the Support Services Director stated the facility was not aware the generator annunciator was not working. Actual NFPA standard: NFPA 99 Chapter 6 Electrical Systems 6-4 Essential Electrical System Requirements - Type 1. 6.4.1.1.17 Alarm Annunciator. A remote annunciator that is storage battery powered shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station (see 700.12 of NFPA 70, National Electrical Code). The annunciator shall be hard-wired to indicate alarm conditions of the emergency or auxiliary power source as follows: (1) Individual visual signals shall indicate the following: (a) When the emergency or auxiliary power	K 916		

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SYRINGA CHALET NURSING FACILITY	700 EAST ALICE STREET BLACKFOOT, ID 83221

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K 916	Continued From page 9 source is operating to supply power to load (b) When the battery charger is malfunctioning (2) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate the following: (a) Low lubricating oil pressure (b) Low water temperature (below that required in 6.4.1.1.11) (c) Excessive water temperature (d) Low fuel when the main fuel storage tank contains less than a 4-hour operating supply (e) Overcrank (failed to start) (f) Overspeed	K 916		