



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

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

March 8, 2018

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 **February 27, 2018**, 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 **March 21, 2018**. Failure to submit an acceptable PoC by **March 21, 2018**, may result in the imposition of civil monetary penalties by **April 10, 2018**.

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 may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **April 3, 2018**, (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 3, 2018**. A change in the seriousness of the deficiencies on **April 3, 2018**, may result in a change in the remedy.

Tamara Gillins, Administrator  
March 8, 2018  
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The remedy, which will be recommended if substantial compliance has not been achieved by **April 3, 2018**, includes the following:

Denial of payment for new admissions effective **May 27, 2018**.  
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 **August 27, 2018**, 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 **February 27, 2018**, 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:

Tamara Gillins, Administrator  
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<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 **March 21, 2018**. If your request for informal dispute resolution is received after **March 21, 2018**, 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: 03/07/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135111</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/27/2018</b>
NAME OF PROVIDER OR SUPPLIER <b>SYRINGA CHALET NURSING FACILITY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>700 EAST ALICE STREET BLACKFOOT, ID 83221</b>		
(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
E 000	Initial Comments  The facility is a four story type II (222) fire resistive building with multiple exits to grade, that was last renovated in 1996. The facility has an on-site, diesel powered generator system, is fully sprinklered and equipped with an interconnected fire alarm that is both on-site and off-site monitored. The facility is located in the a municipal fire district and is currently licensed for 29 SNF/NF beds, with a census of 28 on the date of the survey.  The following deficiencies were cited during the Emergency Preparedness survey conducted on February 27, 2018. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73.  The Survey was conducted by:  Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	E 000		
E 039 SS=F	EP Testing Requirements CFR(s): 483.73(d)(2)  (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following:  *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:]	E 039		

**RECEIVED**  
MAR 23 2018  
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Tamara Hillier NHA, LCSW* TITLE *Administrator* (X6) DATE *3/22/18*

A 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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E 039	<p>Continued From page 1</p> <p>(i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event.</p> <p>(ii) Conduct an additional exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or individual, facility-based.</p> <p>(B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.</p> <p>*[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following:</p> <p>(i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the</p>	E 039	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b> There were no residents named specifically in the citation.</p> <p><b>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;</b> All residents have the potential to be affected by this deficient practice. See the corrective measures identified below.</p> <p><b>What measures will be put into place or what systemic changes you will make to ensure that deficient practice does not recur;</b> State Hospital South (SHS) conducts two or more emergency exercises a year. Syringa Chalet Nursing Facility (SCNF) staff will participate in a full-scale community-based exercise planned by Southeastern Idaho Public Health on 4/11/2018. This exercise is designed as a medical materials request and communications exercise. Additionally, SCNF staff will participate in a SHS tabletop exercise in July where residents will be evacuated notionally from the Syringa building to an on-campus location and from there to an off-site facility.</p>	

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E 039	<p>Continued From page 2</p> <p>[RNHCl's and OPO's] emergency plan, as needed.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, it was determined the facility failed to participate in two exercises which tested the emergency preparedness readiness of the facility. Failure to participate in full-scale, actual, or tabletop events has the potential to reduce the facility's effectiveness to provide continuation of care to residents during an emergency. This deficient practice affected 28 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>On 2/27/18 from 11:30 AM - 12:00 PM, review of a provided documentation of a hospital exercise conducted on the property on 11/1/2017, did not demonstrate it was separate, distinct and/or included response and participation of the LTC (Long Term Care) facility. Further review of all after-action documentation did not demonstrate what, if any, relevant information affected the actions or response of LTC personnel, or if any changes to the EP had been determined as necessary.</p> <p>Interview of the Program Specialist that helped organize the exercise on 2/27/18 from 12:30 - 1:00 PM, revealed he was not aware the conducted exercise of the hospital did not meet the requirement.</p> <p>Reference: 42 CFR 483.73 (d) (1)</p>	E 039	<p><b>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 Attendance logs will be kept of SCNF involvement. SCNF Administrator/Designee will assist in evaluating the exercises to determine if the response was consistent with the Emergency Operations Plan or if policy changes or additional staff trainings are needed. Results will be reported at the Quarterly QA/PI Meeting. Include dates when corrective action will be completed: 4/3/18</b></p>	4/3/18
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K 000	<p><b>INITIAL COMMENTS</b></p> <p>The facility is a four story type II (222) fire resistive building with multiple exits to grade, that was last renovated in 1996. Residents are currently being housed on the first and second level, with controlled access for clinical need. The ground floor is ancillary services only and the fourth floor currently is primarily used as auxillary office and storage. A complete fire sprinkler system was installed in June of 2012, with an interconnected fire alarm system that has both off-site and on-site monitoring. The building is currently licensed for 29 SNF/NF beds with a census of 28 on the date of the survey.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on February 27, 2018. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.</p> <p>The Survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	K 000		
K 100 SS=F	<p>General Requirements - Other CFR(s): NFPA 101</p> <p>General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to</p>	K 100		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Amara Hillier</i> NHA, LCSW Administrator	TITLE	(X6) DATE 3/22/18
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A 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 100	<p>Continued From page 1</p> <p>demonstrate implementation of a water management program for waterborne pathogens such as Legionella, in accordance with 42 CFR 483.80. Failure to conduct a facility based risk assessment or define testing protocols as part of the water management program, has the potential to limit relevant facility awareness and expose residents to Legionella and other water source bacterium based on inconclusive data. This deficient practice affected 29 residents; staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>1) During review of provided water management program documentation conducted on 2/27/18 from approximately 9:30 - 10:00 AM, revealed a section titled "Legionella Risk Assessment". Further review of this section demonstrated some reasonable areas of possible control measures, but failed to demonstrate or identify what, if any, risk was present and why such an area might pose a potential risk.</p> <p>2) Additional review of provided documentation, did not indicate any testing protocols had been established through evaluation of a facility based risk assessment.</p> <p>CFR standard: 42 CFR 483.80</p> <p>§ 483.80 Infection control. 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.</p> <p>Additional reference: Center for Medicaid/Medicare Services S &amp; C</p>	K 100	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; There were no residents named specifically in the citation.</p> <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 exposed to Legionella and waterborne pathogens. See the corrective measures identified below.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that deficient practice does not recur; A facility-based risk assessment was completed for waterborne pathogens such as Legionella. Water systems affecting Syringa were carefully mapped with areas of risk identified. With each area, the level of risk (low, moderate, high) and the specific type of risk (ingestion, inhalation, aspiration) were identified. The testing protocols and control measures which are currently in place were identified. Based on the risk assessment, testing protocols and control measures, the potential for waterborne pathogens at Syringa is monitored and kept at a minimum, if not eliminated. There have been no reported waterborne illnesses in at least the past 10 years. See Attachments</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place, and The Syringa facility-based risk assessment and policies related to managing waterborne pathogens are reviewed annually and will be revised as needed if illnesses from waterborne pathogens are identified. Results will be reported at the Quarterly QA/PI Meeting.</p>	4/3/18

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NAME OF PROVIDER OR SUPPLIER <b>SYRINGA CHALET NURSING FACILITY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>700 EAST ALICE STREET BLACKFOOT, ID 83221</b>
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K 100	Continued From page 2 letter 17-30	K 100		
K 325 SS=F	<p>Alcohol Based Hand Rub Dispenser (ABHR) CFR(s): NFPA 101</p> <p>Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met:</p> <ul style="list-style-type: none"> <li>* Corridor is at least 6 feet wide</li> <li>* Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols</li> <li>* Dispensers shall have a minimum of 4-foot horizontal spacing</li> <li>* Not more than an aggregate of 10 gallons of fluid or 136 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room</li> <li>* Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30</li> <li>* Dispensers are not installed within 1 inch of an ignition source</li> <li>* Dispensers over carpeted floors are in sprinklered smoke compartments</li> <li>* ABHR does not exceed 95 percent alcohol</li> <li>* Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11)</li> <li>* ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485</li> </ul> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure manually operated Alcohol Based Hand Rub Dispensers (ABHR), were maintained in accordance with NFPA 101. Failure to install, test and document operation of ABHR dispensers under manufacturer's recommendations and in accordance with the standard, has the potential of increasing the risk of fires from flammable liquids.</p>	K 325	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; There were no residents named specifically in the citation.</p> <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 this deficient practice. See the corrective measures identified below.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that deficient practice does not recur; The ABHR dispenser cited in the beauty salon was removed on 2/28/2018. All manual and automatic refill dispensers in the facility have been numbered. A refill log was developed where custodial staff can document the dispenser # and date of refill. The form includes manual/automatic dispenser refill and cleaning instructions. Staff sign and date each refill acknowledging that instructions were followed and the unit is dispensing properly.</p> <p>See Attachments</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and The refill log will be reviewed monthly for 3 months by the Custodial Department Supervisor and the Support Services Director to ensure compliance. Results will be reported at the Quarterly QA/PI Meeting.</p>	3/26/18

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NAME OF PROVIDER OR SUPPLIER <b>SYRINGA CHALET NURSING FACILITY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>700 EAST ALICE STREET BLACKFOOT, ID 83221</b>		
(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 325	<p>Continued From page 3</p> <p>This deficient practice affected 28 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>1) During review of facility maintenance and inspection records conducted on 2/27/18 from approximately 9:30 - 10:30 AM, no records were available indicating procedures performed for installed ABHR dispensers when refilling. Asked what documentation was done during this process, the Administrator stated the facility was not documenting the refill process and was not aware of the requirement to test ABHR dispensers each time a refill was installed.</p> <p>2) During the facility tour conducted on 2/27/18 from 10:00 AM - 12:00 PM, observation of installed ABHR dispensers revealed both automatic and manually activated dispensers had been installed on all four levels. Further observation of the Beauty Salon on the lower ancillary level, revealed an ABHR dispenser installed directly over an outlet.</p> <p>Actual NFPA standard:</p> <p>NFPA 101</p> <p>19.3.2.6* Alcohol-Based Hand-Rub Dispensers. Alcohol-based hand-rub dispensers shall be protected in accordance with 8.7.3.1, unless all of the following conditions are met:</p> <p>(1) Where dispensers are installed in a corridor, the corridor shall have a minimum width of 6 ft (1830 mm).</p> <p>(2) The maximum individual dispenser fluid capacity shall be as follows:</p>	K 325		

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

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135111</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/27/2018</b>
NAME OF PROVIDER OR SUPPLIER <b>SYRINGA CHALET NURSING FACILITY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>700 EAST ALICE STREET BLACKFOOT, ID 83221</b>		
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K 325	Continued From page 4  (a) 0.32 gal (1.2 L) for dispensers in rooms, corridors, and areas open to corridors (b) 0.53 gal (2.0 L) for dispensers in suites of rooms  (3) Where aerosol containers are used, the maximum capacity of the aerosol dispenser shall be 18 oz. (0.51 kg) and shall be limited to Level 1 aerosols as defined in NFPA30B, Code for the Manufacture and Storage of Aerosol Products. (4) Dispensers shall be separated from each other by horizontal spacing of not less than 48 in. (1220 mm). (5) Not more than an aggregate 10 gal (37.8 L) of alcohol-based hand-rub solution or 1135 oz (32.2 kg) of Level 1 aerosols, or a combination of liquids and Level 1 aerosols not to exceed, in total, the equivalent of 10 gal (37.8 L) or 1135 oz (32.2 kg), shall be in use outside of a storage cabinet in a single smoke compartment, except as otherwise provided in 19.3.2.6(6). (6) One dispenser complying with 19.3.2.6 (2) or (3) per room and located in that room shall not be included in the aggregated quantity addressed in 19.3.2.6(5). (7) Storage of quantities greater than 5 gal (18.9 L) in a single smoke compartment shall meet the requirements of NFPA 30, Flammable and Combustible Liquids Code. (8) Dispensers shall not be installed in the following locations: (a) Above an ignition source within a 1 in. (25 mm) horizontal distance from each side of the ignition source (b) To the side of an ignition source within a 1 in. (25mm) horizontal distance from the ignition source (c) Beneath an ignition source within a 1 in. (25	K 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135111</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02 - ENTIRE BUILDING</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/27/2018</b>
NAME OF PROVIDER OR SUPPLIER <b>SYRINGA CHALET NURSING FACILITY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>700 EAST ALICE STREET BLACKFOOT, ID 83221</b>		
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K 325	Continued From page 5 mm) vertical distance from the ignition source (9) Dispensers installed directly over carpeted floors shall be permitted only in sprinklered smoke compartments. (10) The alcohol-based hand-rub solution shall not exceed 95 percent alcohol content by volume. (11) Operation of the dispenser shall comply with the following criteria: (a) The dispenser shall not release its contents except when the dispenser is activated, either manually or automatically by touch-free activation. (b) Any activation of the dispenser shall occur only when an object is placed within 4 in. (100 mm) of the sensing device. (c) An object placed within the activation zone and left in place shall not cause more than one activation. (d) The dispenser shall not dispense more solution than the amount required for hand hygiene consistent with label instructions. (e) The dispenser shall be designed, constructed, and operated in a manner that ensures that accidental or malicious activation of the dispensing device is minimized. (f) The dispenser shall be tested in accordance with the manufacturer ' s care and use instructions each time a new refill is installed.	K 325		