



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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DAVE JEPPESEN- Director

TAMARA PRISOCK—ADMINISTRATOR  
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3232 Elder Street  
P. O. Box 83720  
Boise, Idaho 83720-0009  
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September 9, 2019

Tamara Gillins, Administrator  
Syringa Chalet Nursing Facility  
700 East Alice Street,  
Blackfoot, ID 83221-4925

Provider #: 135111

Dear Ms. Gillins:

On **August 23, 2019**, a survey was conducted at Syringa Chalet Nursing Facility by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. 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. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3.) **Please provide ONLY ONE completion date for each federal and state tag (if applicable) 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 the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **September 19, 2019**. Failure to submit an acceptable PoC by **September 19, 2019**, may result in the imposition of civil monetary penalties by **October 27, 2019**.

The components of a Plan of Correction as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained; and
- Include dates when corrective action will be completed in column (X5).

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 the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

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

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

**Civil Monetary Penalty**  
**Denial of payment for new admissions effective November 23, 2019**

Tamara Gillins, Administrator  
September 9, 2019  
Page 3

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **February 23, 2020**, 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, CMS will provide you with a separate formal notification of that determination.**

If you believe these deficiencies have been corrected, you may contact Laura Thompson, RN or Belinda Day, RN, Supervisors LTC Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; 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.

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 **September 19, 2019**. If your request for informal dispute resolution is received after **September 19, 2019**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Tamara Gillins, Administrator  
September 9, 2019  
Page 4

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Belinda Day, RN, or Laura Thompson, RN, Supervisors, Long Term Care Program at (208) 334-6626, option #2.

Sincerely,



Sylvia Creswell, LSW, Supervisor  
Long Term Care Program

sc/lj  
Enclosures

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

PRINTED: 11/01/2019  
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>08/23/2019</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	
F 000	INITIAL COMMENTS  The following deficiencies were cited during the federal recertification and complaint investigation survey conducted from August 19, 2019 to August 23, 2019.  The surveyors conducting the survey were:  Presie C. Billington, RN, Team Coordinator Cecilia Stockdill, RN Sallie Schwartzkopf, LCSW  BPH = Benign Prostatic Hyperplasia CNA = Certified Nursing Assistant DNR = Do Not Resuscitate DNS = Director of Nursing Services LPN = Licensed Practical Nurse LSW = Licensed Social Worker MDS = Minimum Data Set mg = Milligrams PA-C = Physician Assistant - Certified POST = Physician Scope of Treatment RN = Registered Nurse	F 000			
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2)  §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.  §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's	F 550		10/3/19	

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

TITLE

(X6) DATE

Electronically Signed

09/19/2019

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 550	<p>Continued From page 1</p> <p>individuality. The facility must protect and promote the rights of the resident.</p> <p>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.</p> <p>§483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.</p> <p>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and resident and staff interview, it was determined the facility failed to ensure residents' urinary drainage bags were kept in a privacy bag. This was true for 1 of 2 residents (Resident #25) reviewed for urinary catheters, and created the potential for harm should residents experience embarrassment related to their exposed urinary drainage bag. Findings include:</p>	F 550	<p>F550 Resident Rights</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #25 Resident's urinary drainage bag will be covered with a privacy bag while in and out of room to promote</p>		

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F 550	<p>Continued From page 2</p> <p>The facility's policy for urinary catheters, dated 7/1/12, directed staff to "maintain resident's privacy and dignity."</p> <p>Resident #25 was admitted to the facility on 10/18/17, with multiple diagnoses including schizoaffective disorder and benign prostatic hyperplasia (enlargement of the prostate).</p> <p>Resident #25's quarterly MDS assessment, dated 7/9/19, documented he was cognitively intact and required an indwelling catheter.</p> <p>On 8/19/19 at 3:36 PM, Resident #25 was sitting in a recliner in his room. A urinary drainage bag was observed in a pink basin on the floor. The urinary drainage bag was not in a privacy bag, and the contents of the urinary drainage bag were readily visible to anyone who passed by the doorway or entered the room. A privacy bag was hanging from the seated walker adjacent to Resident #25's recliner. Resident #25 said he had a catheter in place because he could not urinate, and staff placed the urinary drainage bag in the privacy bag only when he walked down to the dining room.</p> <p>On 8/20/19 at 8:51 AM, Resident #25 was sitting in his recliner in his room. A trash can was next to the recliner and the urinary drainage bag was hanging off the trash can. The urinary drainage bag was not in a privacy bag.</p> <p>On 8/21/19 at 10:13 AM, Resident #25 was sitting in his recliner in his room. The urinary drainage bag was in a pink basin on the floor. The urinary drainage bag was not in privacy bag</p>	F 550	<p>dignity and privacy.</p> <p>How you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken: All other residents reviewed with one other resident using a urinary drainage bag. It will be kept in a privacy bag inside and outside of room.</p> <p>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: Staff in-serviced on 9/17/19 on the use of privacy bags. Additionally, the use of privacy bags will be added to The New Employee Orientation Checklist.</p> <p>How the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained: To ensure dignity and privacy, random observations of urinary drainage bags will be conducted 3 x weekly each shift by the DNS/Designee for 4 weeks, then 2 x weekly each shift for 8 weeks. Audits to begin week of 9/30/19. Results reported at Quarterly QA/PI Meetings.</p>		

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F 550	Continued From page 3 and was visible from the doorway. CNA #1 said that was the way the drainage bag was typically stored. CNA #1 said there was a privacy bag on Resident #25's walker, and staff placed the urinary drainage bag in the privacy bag just when he was up and walking around.	F 550			
F 552 SS=D	On 8/21/19 at 10:20 AM, RN #1 said Resident #25's urinary drainage bag was to be in a privacy bag. Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5)  §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including:  §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.  §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care.  §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to obtain informed consent for 1 of 5 residents (Resident #8) reviewed for psychotropic medication. This	F 552	F552 Right to be Informed/Make Treatment Decisions  What corrective action(s) will be	10/3/19	

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F 552	<p>Continued From page 4</p> <p>deficient practice placed residents at risk of receiving psychotropic medications without knowledge of the risks and benefits associated with each medication, alternative treatment options, and the right to refuse the medication. Findings include:</p> <p>Resident #8 was admitted to the facility on 12/4/07, with multiple diagnoses including schizoaffective disorder (a chronic mental health condition characterized by hallucinations, delusions, mania, and depression), dementia, and medication induced dyskinesia (involuntary muscle movements).</p> <p>Resident #8's August 2019 Physician's Orders documented he was receiving Trileptal tablets 150 milligrams orally twice a day for treatment of schizoaffective disorder and mood instability.</p> <p>Resident #8's physician's progress notes documented he received Trileptal from 9/17/12 to 11/17/16. A physician's order, dated 2/12/18, documented the Trileptal was restarted. Resident #8's record did not include a consent for the Trileptal when it was reordered.</p> <p>On 8/20/19 at 2:03 PM, the Administrator said Resident #8 had a daughter who made decisions for him.</p> <p>On 8/23/19 at 12:30 PM, the DNS said the facility did not need a consent for the Trileptal because it was classified as an antiseizure medication, not a psychotropic medication.</p> <p>On 8/23/19 at 2:07 PM, the Physician said the facility did not need a consent for the Trileptal</p>	F 552	<p>accomplished for those residents found to have been affected by the deficient practice: Resident #8 Resident representative contacted and educated on the risks and benefits, alternative treatment options, and the right to refuse medication(s). Informed Consent obtained for Trileptal, and any other medications affecting brain activity.</p> <p>How you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken: All other resident's medication orders reviewed and compared to their Informed Consent on file. Residents needing Consents identified and Consents obtained for those residents taking Psychotropic Medications and other medications affecting brain activity. Staff in-serviced on 9/17/19 and 9/24/19 on this regulation.</p> <p>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: Resident Rights Policy and Psychotropic Consent Policy and Form revised to include other medications which may affect brain activity. Medical Director and PA to obtain their own consents prior to prescribing medications or if assistance needed, they will contact DNS, ADNS or charge nurse to obtain consent. Licensed nurse will notify Physician/PA when consent is obtained so medication can be prescribed. Education on this regulation added to</p>		

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F 552	Continued From page 5 because it was not classified as a psychotropic medication.  Resident #8 and/or his representative was not provided the opportunity to consider all options before making the decision to add Trileptal to Resident #8's medication regimen.	F 552	Licensed Nurse Orientation Checklist.  How the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained: Audits of new medication orders on all residents 5 x weekly for 2 weeks, then 3 x weekly for 4 weeks, then 2 x weekly for 6 weeks to determine if prior consent was obtained. At the conclusion of this audit, an on-going weekly audit in Treatment Team of those residents with an MDS review will compare Psychotropic medication orders with consents to ensure compliance. Results reported at Quartely QA/PI Meeting.		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)  §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.  §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.  §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the	F 578		10/3/19	

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F 578	<p>Continued From page 6</p> <p>resident's option, formulate an advance directive.</p> <p>(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.</p> <p>(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.</p> <p>(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview, it was determined the facility failed to ensure residents and residents' representatives had the right to formulate an Advance Directive. This was true for 1 of 7 residents (Resident #8) reviewed for Advance Directives. The deficient practice created the potential for harm should residents' wishes regarding end of life or emergent care not be honored when they were incapacitated.</p> <p>Findings include:</p> <p>The State Operations Manual (SOM) defined an Advance Directive as "a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether</p>	F 578	<p>F578 Request/Refuse/Discontinue Treatment; Formulate Advance Directives</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #8 Contacted resident's daughter, who is the primary decision maker(9/18/2019)to review existing instructions on the POST to determine whether she wished to change or continue with these instructions. Resident lacks the capacity to formulate Advance Directives. She expressed the desire to continue with the same</p>		

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F 578	<p>Continued From page 7</p> <p>statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated." The SOM defined a Physician Orders for Life-Sustaining Treatment (or POLST) as "a form designed to improve patient care by creating a portable medical order form that records patients' treatment wishes so that emergency personnel know what treatments the patient wants in the event of a medical emergency, taking the patient's current medical condition into consideration. A POLST paradigm form is not an advance directive. ...If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether he or she has executed an advance directive or not, the facility may give advance directive information to the individual's resident representative in accordance with State Law."</p> <p>1. Resident #8 was admitted to the facility on 12/4/07, with multiple diagnoses including schizoaffective disorder, dementia, chronic obstructive pulmonary disease (COPD - a lung disease resulting in shortness of breath), atrial fibrillation (irregular heart rhythm), heart failure, and orthostatic hypotension (low blood pressure with change in position).</p> <p>On 8/20/19 at 2:03 PM, the Administrator said Resident #8 had a daughter who made decisions for him.</p> <p>No documentation regarding Advance Directives being discussed with Resident #8 and/or his daughter were found in Resident #8's record.</p> <p>On 8/23/19 at 12:30 PM, the Administrator said</p>	F 578	<p>instructions.</p> <p>How you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken: All other residents reviewed, and any with decision-making capacity, who hadn't formulated Advance Directives were re-educated and given the opportunity to complete. Staff in-serviced on 9/17/19 and 9/24/19.</p> <p>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: All residents given the opportunity on admission to complete Advance Directives, if not already completed. Assistance given as requested to complete Directives. If resident lacks capacity, and no Directives have been completed, the primary decision-maker is contacted and educated on completing an Advance Directive, if not already completed. The Treatment Team reviews the existing instructions with residents/Resident Representatives on a routine basis after completion of the MDS and during the care conference to determine if the wish for existing directions is to change or continue. There are more frequent reviews with a change in condition.</p> <p>How the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is</p>		

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F 578	Continued From page 8 they did not have periodic conversations with residents' representatives regarding Advanced Directives. The Administrator provided an Administrative Progress Note, dated 8/22/19 (the day before), which documented her conversation with Resident #8's daughter. The note documented Resident #8's daughter said an Advance Directive was not completed for him.  The facility failed to provide Resident #8 and/or his representative with information regarding Advance Directives and offer assistance to formulate Advanced Directives.	F 578	sustained: Weekly audits on an on-going basis during Care Conferences to ensure compliance with routine reviews. Audits to begin week of 9/30. Results reported at Quarterly QA/PI Meetings.		
F 684 SS=D	Quality of Care CFR(s): 483.25  § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on policy review, record review, and staff interview, it was determined the facility failed to ensure neurological assessments were completed following unwitnessed falls as directed in the facility's neurological checks policy. This was true for 1 of 2 residents (Resident #3) reviewed for falls. This deficient practice created the potential for harm if changes in residents' neurological status went undetected and untreated after falls. Findings include:	F 684	F684 Quality of Care  What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #3 Neurological Checks completed per Protocol on all unwitnessed falls for this resident.  How you will identify other residents who	10/3/19	

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F 684	<p>Continued From page 9</p> <p>The facility's Neurological Check Protocol policy and procedure, last reviewed 4/11/19, documented:</p> <ul style="list-style-type: none"> <li>* Neurological checks are to be used for residents whose physical condition is such that they require increased staff assessment of monitoring to ensure their wellbeing.</li> <li>* Neurological checks may be initiated by the Unit Provider, Clinical Supervisor, Director of Nursing, Charge Nurse and/or House Supervisor by writing an order in CPRS (the facility's computerized record keeping system).</li> <li>* The order for neurological checks may contain the time frame for the checks otherwise staff are to follow the Neurological Observation Flow Sheet for the documentation and the duration of the checks.</li> <li>* A nursing progress note shall be made at least each shift by a nurse to document the resident's current neurological status.</li> <li>* Neurological checks shall be discontinued after 24 hours unless specified in the orders.</li> </ul> <p>The facility's Neurological Observation Flow Sheet documented neurological assessments were completed every 15 minutes for 1 hour, every 30 minutes for 1 hour, every 60 minutes for 4 hours, and every 4 hours for 24 hours, for a total of 17 assessments, with direction to progress along this time schedule only if signs were stable, and to contact the physician if signs were unstable. The Neurological Observation Flow Sheet also provided space for documented</p>	F 684	<p>have the potential to be affected by the same deficient practice and what corrective action(s) will be taken: All other residents at risk of Neurological Checks not being completed per Protocol on all unwitnessed fall. Staff in-serviced on accurate and complete completion of "Neurological Observation Worksheet" on 9/17/19 and 9/24/19.</p> <p>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: Staff to awaken residents when sleeping to complete Neurological Checks. "Sleeping" will not be entered on the Worksheet. A Nursing Progress Note will be completed with any refusal. DNS/ADNS and/or Charge Nurses to monitor proper completion of Worksheet during each shift to ensure timely assessment/interventions with residents and accurate and complete documentation on the Form.</p> <p>How the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained: DNS/ADNS or Licensed Nurse Designee to audit Neurological Check Worksheet(s) as completed on all unwitnessed falls the following day on an on-going basis to ensure accurate completion of Form and as another way to provide oversight and ensure timely assessment/interventions with resident care. Audits to begin week of 9/23. Results reported at Quarterly QA/PI</p>		

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F 684	<p>Continued From page 10</p> <p>date, time, Glasgow Scale (a tool used to measure neurological status including eye, motor, and verbal responses), hand grasps, pupil size, pupil reaction, and vital signs (blood pressure, pulse, respiration rates), initials and name of staff, and to see nurse's notes if applicable.</p> <p>Resident #3 was admitted to the facility on 10/4/13, with multiple diagnoses including bipolar disorder (mood swings ranging from depressive lows to manic highs), severe depression with psychotic features (a disconnection from reality), anxiety, dementia, and diabetes mellitus type 2.</p> <p>Neurological checks were not completed after Resident #3's unwitnessed falls, as follows:</p> <p>a. A Progress Note, dated 6/30/19 at 11:10 PM, documented Resident #3 had an unwitnessed fall, was found sitting on the fall mat on the floor in his room with no apparent injury, and neurological assessments were started.</p> <p>A Fall Scene Investigation Report, dated 6/30/19 at 11:36 PM, documented Resident #3 was found at 11:10 PM sitting on the fall mat on the floor in his room and neurological assessments were initiated.</p> <p>The Neurological Observation Flow Sheet for Resident #3 started on 6/30/19 at 11:15 PM and was scheduled to end on 7/2/10 at 5:15 AM. The Neurological Observation Flow Sheet documented 12 of 17 assessments were not completed, as follows:</p> <p>- The Glasgow Scale, hand grasps, pupil size</p>	F 684	Meeting.		

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F 684	<p>Continued From page 11 and reactions were not documented from 7/1/19 at 12:00 AM to 7/1/19 at 1:15 PM with "sleeping" documented for those times.</p> <p>- Vital signs were not documented from 7/1/19 at 12:45 AM to 7/1/19 to 1:15 PM with "sleeping" documented for those times.</p> <p>- The Glasgow Scale, hand grasps, pupil size and reactions were not documented from 7/1/19 at 9:15 PM to 7/2/19 at 5:15 AM with "sleeping" documented for this time.</p> <p>- Resident #3's vital signs were not documented from 7/2/19 at 1:15 AM through 7/2/19 at 5:15 PM.</p> <p>b. A Progress Note, dated 7/9/19 at 3:40 AM, documented Resident #3 had an unwitnessed fall and was found sitting on the fall mat in his room with no apparent injury.</p> <p>A Fall Scene Investigation Report, dated 7/9/19 at 4:00 AM, documented Resident #3 was found at 3:40 AM on his fall mat next to his bed and neurological assessments were initiated.</p> <p>The Neurological Observation Flow Sheet for Resident #3 started on 7/9/19 at 3:40 AM, and was scheduled for completion on 7/10/19 at 9:40 AM. The Neurological Observation Flow Sheet documented 9 of 17 assessments were not completed, as follows:</p> <p>- Hand grasps, pupil size and reactions were not documented on 7/9/19 at 4:25 AM to 7/9/19 at 9:40 AM with "sleep" documented for those times.</p>	F 684			

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F 684	<p>Continued From page 12</p> <p>- The Glasgow Scale was not documented from 7/9/19 to 4:40 AM to 7/9/19 at 9:40 AM and from 7/10/19 at 1:40 AM to 7/10/19 at 9:40 AM with "sleep" documented for those times.</p> <p>c. A Progress Note, dated 7/16/19 at 1:00 PM, documented Resident #3 had an unwitnessed fall and was found on the fall mat on the floor of his bedroom, with no apparent injury, and neurological checks were started.</p> <p>A Fall Scene Investigation Report, dated 7/16/19 at 2:29 AM, documented Resident #3 was found on 7/15/19 at 11:00 PM in a seated position on the fall mat next to his bed and neurological assessments were ongoing.</p> <p>The Neurological Observation Flow Sheet for Resident #3 started on 7/15/19 at 11:00 PM and was scheduled for completion on 7/17/19 at 5:00 AM. The Neurological Observation Flow Sheet documented 7 of 17 assessments were not completed, as follows:</p> <p>- No neurological assessments were documented from 7/16/19 at 12:30 AM to 7/16/19 at 9:00 AM and "sleeping" was documented for those times.</p> <p>- The Glasgow Scale, hand grasps, pupil size and reactions were not documented on 7/17/19 at 1:00 AM with "sleeping" documented for this time.</p> <p>d. A Progress Note, dated 7/30/19 at 12:00 AM, documented Resident #3 was found sitting on the fall mat on the floor in his room.</p>	F 684			

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PRINTED: 11/01/2019  
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OMB NO. 0938-0391

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F 684	<p>Continued From page 13</p> <p>A Fall Scene Investigation Report, dated 7/30/19 at 1:55 PM, documented Resident #3 was found on his buttocks on the fall mat at 11:00 AM with his back against the bed, his legs out in front, and neurological assessments were initiated due to his unwitnessed fall.</p> <p>The Neurological Observation Flow Sheet for Resident #3 started on 7/30/19 at 11:00 AM, and was scheduled for completion on 7/31/19 at 1:30 PM. The Neurological Observation Flow Sheet documented 2 of 17 assessments were not completed, as follows:</p> <ul style="list-style-type: none"> <li>- No neurological checks were documented on 7/30/19 at 9:30 PM and on 7/31/19 at 1:30 AM with "sleeping" documented for these times.</li> </ul> <p>e. A Progress Note, dated 8/3/19 at 12:00 PM, documented Resident #3 was found lying on his back on the fall mat in his room, no issues noted, and neurological checks were started due to the unwitnessed fall.</p> <p>A Fall Scene Investigation Report, dated 8/3/19 at 5:17 PM, documented Resident #3 fell on 8/3/19 at 12:00 PM, was found on his back on the mat in his room and neurological assessments were started.</p> <p>The Neurological Observation Flow Sheet for Resident #3 started on 8/3/19 at 12:05 PM and was scheduled for completion on 8/14/19 at 1:00 PM. The Neurological Observation Flow Sheet documented 8 of 17 assessments were not completed, as follows:</p> <ul style="list-style-type: none"> <li>- Resident #3's blood pressure was not</li> </ul>	F 684			

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F 684	<p>Continued From page 14 documented on 8/3/19 at 1:00 PM.</p> <ul style="list-style-type: none"> <li>- No neurological assessments were documented on 8/3/19 from 2:00 PM to 4:00 PM and on 8/4/19 from 1:00 AM to 9:00 AM with "sleeping" documented for those times.</li> <li>- Resident #3's respiration rate was not documented on 8/3/19 at 4:00 PM.</li> <li>- Resident #3's Glasgow Scale, hand grasps, and pupil size and reactions were not documented on 8/4/19 at 1:00 PM.</li> </ul> <p>f. A Progress Note, dated 8/12/19 at 10:20 PM, documented Resident #3 was found lying on the fall mat in his room perpendicular to his bed, with no apparent injury.</p> <p>A Fall Scene Investigation Report, dated 8/12/19 at 10:20 AM, documented Resident #3 was found on the fall mat in his room on 8/12/19 at 10:20 AM and neurological assessments were initiated.</p> <p>The Neurological Observation Flow Sheet for Resident #3 started on 8/12/19 at 10:20 AM, and was scheduled for completion at 8/13/19 at 6:05 AM. The Neurological Observation Flow Sheet documented 2 of 17 neurological assessments were not completed, as follows:</p> <ul style="list-style-type: none"> <li>- No neurological assessments were documented from 8/12/19 at 11:05 PM to 8/13/19 at 6:05 AM with "sleeping" documented for those times.</li> </ul> <p>g. A Fall Scene Investigation Report, dated 8/19/19 at 10:20 AM, documented Resident #3 was found sitting on his fall mat next to his bed</p>	F 684			

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F 684	Continued From page 15 on 8/15/19 at 3:20 AM.  The Neurological Observation Flow Sheet for Resident #3 started on 8/15/19 at 3:20 AM and was scheduled for completion at 8/16/19 at 5:50 AM. The Neurological Observation Flow Sheet documented 10 of 17 neurological checks were not completed, as follows:  - No neurological assessments were documented on 8/15/19 from 4:05 AM to 6:50 AM, on 8/15/19 from 8:50 AM to 1:50 PM, and on 8/15/19 from 9:50 PM to 8/16/19 at 5:50 AM, and "sleeping" was documented for those times.  On 8/21/19 at 10:30 AM, RN #1 said the facility performed neurological assessments if the resident had an unwitnessed fall, including vital signs and skin assessments.  On 8/21/19 at 2:42 PM, the DNS said if a resident fall was unwitnessed, or the resident said he/she hit their head, the facility initiated neurological assessments. Upon review of the Neurological Check Protocol policy, the DNS said Resident #3's neurological assessments should have been completed and they were not.	F 684			
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)  §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and  §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents.	F 689		10/3/19	

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F 689	<p>Continued From page 16</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, policy review, observation, and staff interview, it was determined the facility failed to ensure residents' were protected from falls by providing them with appropriate beds. This was true for 1 of 2 residents (Resident #78) reviewed for falls. This resulted in harm to Resident #78 when her clothing caught on a bed extender bar and fell, sustaining a left rib fracture. Findings include:</p> <p>The facility's policy for Fall/Accident Prevention, dated 4/11/19, documented the following:</p> <ul style="list-style-type: none"> <li>* The resident's environment remained as free of accidents/hazards as possible, and each resident received adequate supervision and assistive devices to prevent falls or accidents.</li> <li>* Staff identified environmental factors that may contribute to falling, such as room layout, furniture placement, and lighting.</li> </ul> <p>Resident #78 was admitted to the facility on 12/3/18 and was readmitted on 5/6/19, with multiple diagnoses including somatization disorder (characterized by recurring, multiple, and clinically significant complaints about body symptoms) and chronic pain.</p> <p>Resident #78's quarterly MDS assessment, dated 2/26/19, documented she was cognitively intact and independent with activities of daily living. Resident #78 had no history of falls since admission to the facility.</p> <p>A care plan, initiated on 12/10/18, documented</p>	F 689	<p>F689 Free of Accident Hazards/Supervision/Devices</p> <p>We are submitting an Informal Dispute Request for this Citation. After an honest and extensive review of all documentation--pertinent resident history, diagnoses with associated characteristics, long-standing patterns of self-injurious, drug-seeking behaviors, 2 X-rays showing demineralization of bones and multiple healed rib fractures prior to admission at Syringa, and video re-enactment of the fall, the surveyor's conclusion that the bed extender caused the resident to fall cannot stand. The bed extender was needed to fit the mattress. The resident's environment was free of accident hazards. Furthermore, no action or inaction on our part caused or contributed to the fall or injury of this resident. Bed extenders are commonly used to fit mattresses. In our years of experience, we are unaware of a bed extender ever causing a fall.</p> <p>However, as required, we will provide a response to this citation with an additional process and monitoring to ensure that with every admission, room change, bed change, and mattress change that the mattress fits the bed frame.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient</p>		

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F 689	<p>Continued From page 17</p> <p>Resident #78 was at moderate risk for falls related to her use of psychoactive medications. Interventions included the following:</p> <ul style="list-style-type: none"> <li>* Encourage her to use her wheeled walker correctly and not to sit on the seat to propel herself and staff not to push her while seated on her wheeled walker.</li> <li>* Encourage her to participate in activities that promote exercise and physical activity for strengthening and improved mobility.</li> <li>* Ensure she wore appropriate footwear when using her wheeled walker.</li> <li>* Ensure her call light was within reach, and encourage her to use it for assistance as needed.</li> </ul> <p>A Progress Note, dated 3/5/19 at 6:00 PM, documented Resident #78 reported she was not sleeping at night and the nursing unit she was in was "much louder." The note stated the PA-C discussed with Resident #78 that moving to a different room may help with her sleep because the new room was located on a quieter floor with a slower pace and due to issues she was having with other residents on her unit the move may also be a "better fit."</p> <p>A Progress Note, dated 3/12/19 at 1:48 PM, documented the DNS and the LCSW spoke to Resident #78 about transferring her to another room which was quieter and had a bathroom. Resident #78 became very upset and screamed and threw things in her room.</p> <p>A Progress Note Addendum, dated 3/14/19,</p>	F 689	<p>practice: Resident #78 Discharged</p> <p>How you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken: All other residents could be at increased risk of harm if the mattress doesn't fit the bed. Staff in-serviced 9/17/19 and 9/24/19.</p> <p>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: All beds assessed to ensure that mattress fits the bed frame. Bed frames and mattresses assessed with every new admission, room change, bed frame change, or mattress change to ensure protection from hazards which could increase fall risk and cause injury. Assessment log created.</p> <p>How the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained: Assessment Log audited 2 x weekly for 12 weeks to ensure compliance. Results reported at QA/PI Meeting.</p>		

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F 689	<p>Continued From page 18</p> <p>documented that on 3/13/19 Resident #78 stated she would like to see the room with the bathroom that facility staff suggested she move to and staff took her to view the room. Resident #78 moved to the room with the bathroom and a Progress Note, dated 3/22/19, documented Resident #78 had made some progress since changing rooms as there was decreased stimulation.</p> <p>A Fall Scene Investigation Report, dated 3/24/19 at 7:00 AM, documented at 5:40 AM Resident #78 was heard cussing under her breathe in her room. The staff then heard a thud coming from Resident #78's room and they heard Resident #78 asking for help. When staff entered Resident #78's room, she was observed lying on the floor on her left side facing her closet with her feet towards her bed and her head towards the door. Resident #78 stated she was trying to get up to scratch her back when her pant leg got stuck on the extender bar of her bed frame and she fell onto her left knee and then to her left side. Resident #78's pants were noted to be loose around both legs and the waist. The report also documented Resident #78 complained of pain in her ribs on the left side. The report documented the extender bars were removed from Resident #78's bed immediately after the fall.</p> <p>Alert Charting Notes for Resident #78 documented she complained of pain after the fall on 3/24/19, as follows:</p> <p>- An Alert Charting Note, dated 3/24/19 at 1:21 PM, documented Resident #78 was crying, yelling, hitting walls and cursing throughout the shift. Resident #78 complained of soreness and stated her knees were hurting, and she refused</p>	F 689			

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F 689	<p>Continued From page 19</p> <p>to get out of bed. The note documented Resident #78 received pain medication as ordered.</p> <p>- An Alert Charting Note, dated 3/25/19 at 1:55 PM, documented Resident #78 complained of pain to her knee and she was given pain medication as requested and ordered.</p> <p>- An Alert Charting Note, dated 3/26/19 at 1:34 PM, documented Resident #78 refused to eat breakfast but ate lunch in the day room. Resident #78 complained about stiffness but seemed to be in good spirits most of the shift.</p> <p>- An Alert Charting Note, dated 3/26/19 at 4:07 PM, documented Resident #78 was medicated twice for pain. The note did not state where the pain was located.</p> <p>- An Alert Charting Note, dated 3/27/19 at 9:43 PM, documented Resident #78 was medicated twice for pain. The note did not state where the pain was located.</p> <p>A subsequent chest x-ray report, dated 3/28/19, documented Resident #78 had an x-ray due to pain in her left rib area. The chest x-ray result documented Resident #78 had a left fifth rib fracture near the costochondral junction (joint between the ribs and cartilage located in the front of the rib cage).</p> <p>On 8/21/19 at 2:01 PM, the DNS said Resident #78 complained of inability to go to sleep due to noise in her room. Resident #78 was provided with an ear plug, as well as head phones but she said it did not help her and she continued to complain of the noise in her room. The DNS said</p>	F 689			

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F 689	Continued From page 20 Resident #78 was advised to transfer to another room, which was quieter. The DNS said Resident #78 was transferred to another room previously occupied by a resident who needed a bigger mattress, and an extender bar was placed on the bed to accommodate the bigger mattress. This bed was then used by Resident #78. When asked if Resident #78 needed the bigger mattress and the extender bar, the DNS said "No." The DNS said the extender bars were missed during a room assessment when the room was prepared for Resident #78.  On 8/23/19 at 11:01 AM, RN #1 showed the surveyor a bed with an extender bar attached. RN #1 said she was on duty the morning Resident #78 fell. RN #1 said the mattress was on top of the extender bar and it was not visible when the mattress was on it. RN #1 said when staff heard a thud and heard Resident #78 ask for help, they went to her room and saw her on the floor. RN #1 said she saw Resident #78's mattress pushed slightly to the left exposing the extender bar. RN #1 said that was the time she found out there was an extender bar attached to Resident #78's bed. RN #1 said the bed extender bars were removed immediately after Resident #78's fall.	F 689			
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)  §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		10/3/19	

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F 880	Continued From page 21  §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:  §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;  §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.	F 880			

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F 880	<p>Continued From page 22</p> <p>(v) The circumstances under which 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; and</p> <p>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on contract review, policy review, observation, and staff interview, it was determined the facility failed to ensure infection control surveillance of the contracted laundry services which processed residents' personal laundry. This deficient practice hand the potential to impact 27 of 27 residents (#1 - #22, #24 - #27, and #79) residing in the facility, all of whom relied on the facility for laundering of personal clothing. The facility also failed to ensure appropriate hand hygiene was completed during dressing changes. This was true for 1 of 12 residents (Resident #19) reviewed for infection control. These deficient practices placed residents at risk of infection. Findings include:</p>	F 880	<p>F880 Infection Prevention and Control</p> <p>Contracted Laundry Services</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Residents #1-#22, #24-#27, and #79 Facility providing Infection Control surveillance of Offsite Laundry Services used for residents' personal laundry through review of documentation and on-site visit 9/18/2019 using newly developed Laundry Infection Form audit tool.</p>		

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F 880	<p>Continued From page 23</p> <p>The contract between the facility, and the contracted company providing personal laundry and mending services documented the service requirement as:</p> <p>"The Contractor shall comply with all applicable rules, regulations and policies as outlined by the Department of Health and Welfare (Department), the State of Idaho, and local, state and national standards, including The Joint Commission, relating to patient care and hospital operations."</p> <p>The facility and a hospital on the same property, were owned by the same organization.</p> <p>The contract did not include a description of the specific cleaning process or products being used. The facility did not provide documentation regarding how the facility monitored the contractor's process to ensure it met the required standards.</p> <p>On 8/22/19 at 9:42 AM, the Administrator said all laundry was contracted to outside contractors.</p> <p>On 8/22/19 at 9:47 AM, the Infection Preventionist (IP) said the laundry services were contracted offsite, one contractor for linens and another for personal clothing. The IP said she visited and reviewed the contractor's facility and protocols. The IP provided processing and wash formula information from the contractor for linens. The IP did not provide processing and wash formulas from the contractor providing personal clothing laundry services. The facility did not provide documentation that it monitored the contractor's laundry processing of residents' clothing, or the specific guidelines used by the</p>	F 880	<p>How you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken: All other residents in the facility use Offsite Laundry Services for personal laundry and could be affected. Contractor provided documents including:</p> <ol style="list-style-type: none"> <li>1. Procedure for washing machines/dryers maintenance that is in accordance with manufacturer's instructions for use.</li> <li>2. Written description of cleaning process and wash formulas.</li> <li>3. Written description of processing, handling, transporting, and delivery of resident linens.</li> </ol> <p>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: Syringa Policy and procedure developed for Laundry Handling, Storing, Processing and Transporting. Infection control surveillance completed by a review of services to include:</p> <ol style="list-style-type: none"> <li>1. Review of contractor policies/procedures.</li> <li>2. Review of washing machines/dryers records of maintenance and ensure that they are completed according to the manufacturer's instructions for use.</li> <li>3. Review of cleaning process, including wash formulas.</li> <li>4. Review of processing and handling by either direct observation using Laundry</li> </ol>		

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F 880	<p>Continued From page 24 contractor for residents' clothing.</p> <p>On 8/23/19 at 1:16 PM, the DNS and the Environmental Services Director (ESD), provided the facility's contract with the personal laundry service contractor. The DNS and ESD said when they asked the contractor for the processing and wash formula information used by the personal laundry service contractor, the contractor replied it was not in their contract to provide it.</p> <p>2. The facility's policy for Hand Hygiene, dated 11/4/09, documented hand hygiene was required before applying and after removing gloves, after handling an invasive device, and after contact with body fluids, mucous membranes, non-intact skin, or wound dressings.</p> <p>Resident #19 was admitted to the facility on 10/28/14, with multiple diagnoses including BPH (enlargement of the prostate) with lower urinary tract symptoms and kidney failure.</p> <p>Resident #19's care plan directed nurses to provide care to his suprapubic catheter (a urinary catheter that drains the bladder through an incision in the abdomen) twice daily and as needed with water and 4 by 4's (gauze squares), pat dry, change the drain sponge and secure with tape. The intervention was initiated on 10/25/18 and revised on 11/14/18.</p> <p>Resident #19's quarterly MDS assessment, dated 4/30/19, documented he was cognitively intact and required an indwelling catheter.</p> <p>Resident #19's physician orders documented an order, dated 8/22/19, for the nurse to provide</p>	F 880	<p>Inspection Form for audits and/or review of written contractor documentation ensuring that process prevents contamination of laundry. 5. Contract in the process of being amended to include the above guidelines and completed as quickly as State of Idaho process for amending contracts allows.</p> <p>How the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained: At least annually, audit and surveillance of laundry contracted services will be completed per newly developed policy. If concerns with performance are identified, audit of services will be performed more frequently to ensure provider is meeting requirements. Laundry Inspection Form Audit will be entered into the Infection Control Audits Folder. Audit results reported at quarterly QA/PI Meetings</p> <p>Hand Hygiene During Dressing Changes: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #19 Proper hand hygiene followed during suprapubic dressing changes. Since the citation references LPN #2, this nurse has completed the following training/direct observations:</p>		

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F 880	<p>Continued From page 25</p> <p>suprapubic catheter care daily, and as needed, as follows: Cleanse the area with water and 4 by 4's, pat dry, place dry drain sponge, and secure it with tape if needed.</p> <p>On 8/21/19 at 4:44 PM, LPN #1 said Resident #19's suprapubic catheter dressing change was just changed from twice a day to once a day.</p> <p>On 8/22/19 at 9:43 AM, LPN #2 was observed performing the dressing change to Resident #19's suprapubic catheter as follows: After washing her hands and applying gloves, LPN #2 removed the existing dressing. She then cleansed around the catheter insertion site and cleansed several inches of the catheter tubing from the abdomen outwards, then removed her gloves and did not perform hand hygiene. LPN #2 applied new gloves, retrieved a pen from a pocket in her top, opened a new dressing and wrote the date on it, and applied the new dressing around Resident #19's suprapubic catheter. LPN #2 then removed the used trash bag from the trash can and placed a new trash bag into the trash can. LPN #2 removed the glove from her left hand, did not perform hand hygiene, and exited the room carrying a used trash bag in her gloved right hand and a gray basin containing tape and dressing supplies in her ungloved left hand. LPN #2 walked down the hall carrying the items as previously described and entered the dirty utility room. LPN #2 said she washed her hands before removing Resident #19's old dressing, and then changed her gloves. LPN #2 said she did not wash her hands after removing her gloves and she probably should have.</p>	F 880	<p>1. SHS CDC Hand Hygiene Training was completed by LPN #2 on 09/12/2019. Training goes over hand hygiene moments, hand hygiene technique, glove use, standard precautions, PPE. Link: <a href="https://www.cdc.gov/handhygiene/training/interactiveEducation/frame.htm">https://www.cdc.gov/handhygiene/training/interactiveEducation/frame.htm</a></p> <p>2. 1:1 training provided by DNS on 09/17/2019 and Infection Preventionist on 9/12/2019 to review process of proper hand hygiene with dressing changes.</p> <p>3. DNS provided direct observation of LPN #2 on 9/17/2019 performing a suprapubic catheter dressing change. A new audit tool was used identifying every step in the process of changing a suprapubic dressing through completion of the task with dropping garbage off in soiled utility room followed by hand hygiene.</p> <p>How you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken: All residents reviewed and no other residents have a suprapubic dressing change.</p> <p>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>1. Training: SHS CDC Hand Hygiene Training to be reviewed and completed by all Syringa licensed nursing staff as described above with LPN #2</p> <p>2. Direct observation of all nurses using new audit tool as described above with</p>		

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F 880	<p>Continued From page 26</p> <p>On 8/22/19 at 10:25 AM, the DNS said hand hygiene should be performed between residents, between glove changes, and if you felt your hands were dirty. The DNS said LPN #2 should have performed hand hygiene after removing her gloves during Resident #19's dressing change.</p> <p>On 8/22/19 at 10:51 AM, the Infection Preventionist said hand hygiene should be performed before and after contact with a resident, when going in and coming out of a resident's room, and if touching soiled items. The Infection Preventionist said hand hygiene should also be performed when going from something dirty to clean, and between glove changes.</p>	F 880	<p>LPN #2.</p> <p>3. On-the spot training provided if any deficient practices identified.</p> <p>4. Hand Hygiene with dressing changes currently reviewed with licensed nurses at New Employee Orientation and Annual Ed Fair to ensure competency.</p> <p>Audit data will be entered in a form for data transparency. Data will be used to report on quality of care, identification of training needs and correction of any deficient infection control practices.</p> <p>How the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained: 2 random observations of licensed staff using new audit tool as described above x 4 weeks, then 1 random audit x 8 weeks. Data from random audits will be analyzed quarterly and reported at quarterly facility-wide Infection Control Committee Meetings and quarterly QA/PI meetings at Syringa.</p>		



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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January 16, 2020

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

Provider #: 135111

Dear Ms. Gillins:

On **August 19, 2019** through **August 23, 2019**, an unannounced on-site complaint survey was conducted at Syringa Chalet Nursing Facility. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00008139**

**ALLEGATION #1:**

The facility failed to ensure medications were administered in a timely manner and medications were not abruptly discontinued.

**FINDINGS #1:**

During the survey resident records were reviewed, observations were conducted, residents and resident family were interviewed, staff were interviewed, Resident Council meeting minutes were reviewed, and facility grievances were reviewed.

During an interview a licensed nurse stated medications could be administered to residents 1.5 hours before or 1.5 hours after the scheduled time. The licensed nurse stated that residents' Medication Administration Records (MAR) were checked for medications which were ordered to be given as needed. The licensed nurse stated she looked for the time the medication was administered last to determine whether the resident could receive the medication at the time it was requested.

Three licensed nurses were observed individually passing medications to residents at different times on 8/21/19 at 4:28 PM, 8/22/19 at 10:26 AM and on 8/22/19 at 1:11 PM, and no concerns were noted.

The facility's Grievance file for 7/9/19 through 8/10/19, and Resident Council minutes from January 2019 through August 2019 were reviewed. There were no grievances in the Grievance file or concerns in the Resident Council minutes related to residents' medications not being administered according to schedule or medications being discontinued abruptly.

Thirteen resident records, including one record of a discharged resident, were reviewed for medications. There were no records of medications being abruptly discontinued. Residents' MARs were also reviewed as well as the physician's orders. There were no concerns noted, residents' medications were given as ordered by their physicians.

One closed record documented the resident had been admitted to the facility in 12/2019 and discharged from the facility in 7/2019. The resident's record included a physician's progress note which documented the resident had overdosed on Norco (an opioid used to relieve moderate to severe pain) and Soma (a controlled medication used to treat injuries and other painful muscle conditions). The medications were discontinued prior to the resident's admission to the facility. Her admission physician orders included other medications which were to be given for pain. The resident's MARs were reviewed and documented the resident's medications were given as ordered by her physician within the required time frame. There was no documentation the resident had medications which were discontinued abruptly.

Six residents were interviewed individually on 8/19/19 through 8/20/19, and 7 residents attended a group interview on 8/20/19 at 10:00 AM. No concerns regarding medication administration were expressed during the individual and group interviews. Two family representatives were also interviewed via telephone on 8/20/19 at 10:12 AM and at 11:08 AM, and no concerns were expressed about medication administration.

It could not be determined that the facility failed to ensure medications were administered in timely manner or that medications were abruptly discontinued.

Based on the investigative findings, the allegation could not be substantiated, and no deficient practice was identified.

#### **CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #2:**

Residents are not treated with dignity and respect.

**FINDINGS #2:**

During the survey, resident records were reviewed, facility grievances were reviewed, Resident Council meeting minutes were reviewed, and residents and family were interviewed.

The facility's Grievance file from 7/9/19 through 8/10/19 and Resident Council minutes from January 2019 through August 2019 were reviewed. There were no grievances or concerns in the Resident Council meeting minutes related to residents not being able to receive phone calls when their family members called in the facility or specific residents being targeted when facility items were missing.

Six residents were interviewed individually on 8/19/19 through 8/20/19, and there were no concerns expressed related to not receiving phone calls from their family members. None of the residents expressed concern regarding being asked about missing items.

Two family members were also interviewed via telephone on 8/20/19 at 10:12 AM and at 11:08 AM. The family members stated there were no problems when calling the facility. They said they were able to speak to their family member whenever they called the facility.

Thirteen resident records, including one record of a discharged resident, were reviewed. There were no concerns related to not receiving phone calls or being asked about missing facility items.

One closed record documented the resident was admitted to the facility in 12/2019 and discharged from the facility in 7/2019. The resident's record included a Nursing Progress Note which documented the resident frequently used the facility's telephone. The resident's record documented she was asked once if she had the telephone in her walker or in her room. There was no other documentation the resident was asked about missing items in the facility.

It could not be determined that the facility failed to ensure resident telephone calls were answered and given to the resident or that specific residents were asked first when facility items were missing.

Based on the investigative findings, the allegation could not be substantiated, and no deficient practice was identified.

## **CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

## **ALLEGATION #3:**

The facility failed to ensure residents' rights to privacy and confidentiality are upheld. Facility staff do not knock before entering the residents' rooms and staff talk about residents' confidential information in front of other residents.

## **FINDINGS #3:**

During the survey, observations were conducted, facility grievances were reviewed, Resident Council meeting minutes were reviewed, residents were interviewed, and staff were interviewed.

One licensed practical nurse (LPN) was interviewed on 8/21/19 at 3:44 PM, and 2 certified nursing assistants (CNA) were interviewed on 8/23/19 at 10:03 AM and at 10:08 AM. They stated they received training about protecting residents' confidential information. They stated they knew how to protect residents' confidential information and did not talk about it (residents' confidential information) in front of another residents.

Observations were conducted throughout the survey on 8/19/19 through 8/22/19. Staff were observed knocking on residents' doors before entering their rooms. None of the staff were observed or heard talking about residents' confidential information in front of other residents.

The facility's Grievance file from 7/9/19 through 8/10/19 and Resident Council minutes from January 2019 through August 2019 were reviewed. There were no grievances in the Grievance file or concerns in the Resident Council meeting minutes related to staff not knocking before entering the residents' room or staff talking about residents' confidential information in front of other residents.

Six residents were interviewed individually on 8/19/19 through 8/20/19. The residents stated staff knock on their doors before entering their rooms. The residents said they never heard any of the staff talking about the confidential information of other residents.

Seven residents attended a group interview on 8/20/19 at 10:00 AM. No concerns were expressed about staff not knocking before entering their rooms. None of the residents observed or heard any staff talking about other residents' confidential information to them or to other residents.

It could not be determined that the facility failed to ensure staff knocked before entering the residents' rooms or that staff did not talk about resident's confidential information in front of other residents.

Based on the investigative findings, the allegation could not be substantiated, and no deficient practice was identified.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #4:**

The facility staff do not answer call lights in a timely manner and do not assist residents when needed.

**FINDINGS #4:**

During the survey observations were conducted, resident records were reviewed, facility grievances were reviewed, Resident Council meeting minutes were reviewed, and residents and family were interviewed.

Observations were conducted in various locations, during various activities throughout the survey. Residents were observed to be appropriately groomed and no concerns were identified. Staff were noted to interact appropriately and assist the residents with their needs. A dining observation was conducted on 8/19/19 at 5:08 PM. Staff were observed to assist residents who needed assistance with their meals while other staff walked around the dining area, asking residents if they needed anything.

The facility's Grievance file from 7/9/19 through 8/10/19 and Resident Council minutes from January 2019 through August 2019 were reviewed. There were no grievances or concerns in the Resident Council minutes related to call lights not being answered in a timely manner or residents not receiving assistance when needed.

Six residents were interviewed individually on 8/19/19 through 8/20/19, and 7 residents attended a group interview on 8/20/19 at 10:00 AM. No concerns regarding call lights not being answered in a timely manner or residents not receiving help when needed were expressed during the individual and group interviews.

Two family representatives were also interviewed via telephone on 8/20/19 at 10:12 AM and at 11:08 AM, and no concerns were expressed regarding the care their family member received from the facility. The family representatives did not voice any concerns regarding call lights not being answered in a timely manner.

It could not be determined that the facility failed to ensure call lights were answered in a timely manner or that resident were provided with assistance when needed.

Based on the investigative findings, the allegation could not be substantiated, and no deficient practice was identified.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #5:**

Residents are transferred to other rooms without their permission.

**FINDINGS #5:**

During the survey, resident records were reviewed, facility grievances were reviewed, Resident Council meeting minutes were reviewed, and staff were interviewed.

The facility's Grievance file from 7/9/19 through 8/10/19, and Resident Council minutes from January 2019 through August 2019 were reviewed. There were no grievances or concerns in the Resident Council minutes related to residents being transferred to other rooms without their permission.

Thirteen resident records, including one of a discharged resident, were reviewed. Twelve resident records did not contain information they had concerns with changes to their rooms. One record documented the resident reported to the staff she was not sleeping at night and the nursing unit she was in was "much louder." The note stated the Physician Assistant talked with the resident and it was suggested moving to a different room may help with her sleep because the new room was located on a quieter floor with a slower pace. The note also stated due to issues she was having with other residents on her unit the move may also be a "better fit." A Room Change form, documented the resident was in agreement to move to another room but she refused to sign the form.

The Administrator was interviewed on 8/21/19 at 4:56 PM. The Administrator stated the resident had a history of refusing to sign documents since her admission to the facility.

It could not be determined that the facility transferred residents to other rooms without their permission.

Based on the investigative findings, the allegation could not be substantiated, and no deficient practice was identified.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #6:**

The facility failed to ensure residents' room were at comfortable temperature.

**FINDINGS #6:**

During the survey, observations were conducted, facility grievances were reviewed, Resident Council meeting minutes were reviewed, and residents were interviewed.

Observations were conducted throughout the facility, including multiple resident rooms during the initial tour and throughout the survey week from 8/19/19 through 8/23/19. During the observations the facility's temperature was appropriate and none of the residents expressed concern about the temperature.

The facility's Grievance file from 7/9/19 through 8/10/19, and Resident Council minutes from January 2019 through August 2019 were reviewed. There were no grievances or concerns in the Resident Council minutes related to residents' rooms being too hot or too cold.

Six residents were interviewed individually on 8/19/19 through 8/20/19, and 7 residents attended a group interview on 8/20/19 at 10:00 AM. No concerns regarding residents' rooms being too hot or too cold were expressed during the individual and group interviews. Two family representatives were also interviewed via telephone on 8/20/19 at 10:12 AM and at 11:08 AM. The family representatives said their family member did not express any concern about the temperature in their rooms.

It could not be determined that the facility failed to ensure residents' room were at comfortable temperature.

Based on the investigative findings, the allegation could not be substantiated, and no deficient practice was identified.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #7:**

The facility failed to ensure residents were protected from falls.

### **FINDINGS #7:**

During the survey, facility incident reports were reviewed and staff were interviewed.

The facility's records included a Fall Scene Investigation Report, dated 3/24/19 at 7:00 AM. The report documented at 5:40 AM a resident was heard cussing under her breath in her room. The staff then heard a thud coming from the resident's room and heard the resident asking for help. When staff entered the resident's room, the resident was observed lying on the floor on her left side facing her closet with her feet towards her bed and her head towards the door. The resident stated she was trying to get up to scratch her back when her pant leg got stuck on the extender bar of her bed frame and she fell onto her left knee and then to her left side. The resident's pants were noted to be loose around both legs and the waist. The report also documented the resident complained of pain in her ribs on the left side. The Fall Scene Investigation Report documented the extender bars were removed from the resident's bed immediately after the fall.

A subsequent x-ray report, dated 3/28/19 documented the resident had a left fifth rib fracture near the costochondral junction (joint between the ribs and cartilage located in the front of the rib cage).

The Administrator was interviewed on 8/23/19 at 8:36 AM. The Administrator said the resident was wearing a very loose and big pajama the morning she fell. The Administrator said the resident complained a lot to the facility about not having enough clothes to wear. The Administrator said they asked the resident check on the clothing donated to the facility, but she never went. The Administrator also said the resident agreed to go shopping for clothes one time but on the day they were suppose to go shopping the resident refused to go.

The Director of Nursing Services (DNS) was interviewed on 8/21/19 at 2:01 PM. The DNS stated the resident was transferred to another room previously occupied by a resident who needed a bigger mattress, and an extender bar was placed on the bed to accommodate the bigger mattress. This bed was then used by resident. When asked if the resident needed the bigger mattress and the extender bar, the DNS said "No." The DNS said the extender bars were missed during a room assessment when the room was prepared for the resident.

It was determined the facility failed to ensure residents were protected from falls. Therefore the allegation was substantiated and the facility was cited at F689 for failure to ensure residents' were protected from falls by providing them with appropriate beds.

Tamara Gillins, Administrator  
January 16, 2020  
Page 9 of 9

**CONCLUSIONS:**

Substantiated. Federal deficiencies related to the allegation are cited.

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,

A handwritten signature in black ink, appearing to read "Laura Thompson".

Laura Thompson, RN, Supervisor  
Long Term Care Program

LT/lj