

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135111	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2024
NAME OF PROVIDER OR SUPPLIER Syringa Chalet Nursing Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 700 East Alice Street Blackfoot, ID 83221	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>49552</p> <p>Based on observation, policy review, resident, and staff interview, it was determined the facility failed to ensure residents were treated with dignity and respect. This was true for 4 of 36 residents (#1, #18, #21, and #23) reviewed for respect and dignity. This deficient practice placed residents at risk of embarrassment and diminished sense of worth. Finding include:</p> <p>The facility's Dignity policy, dated 5/9/24, documented the facility would promote care for residents in a manner and in an environment, that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>The following residents were observed in an open area of the facility and had received medication or had their blood sugar checked:</p> <p>1. On 12/2/24 at 7:44 AM, Resident #1 was observed sitting outside the dining room, waiting for her breakfast. Two other residents were sitting in the hallway and were able to observe RN #1 checking Resident #1's blood sugar.</p> <p>Resident #1's medical record did not document her wish to have her blood sugar checked in common areas.</p> <p>2. On 12/3/24 at 7:48 AM, Resident #21 was observed sitting in the dining room, drinking a beverage. Another resident was sitting across the table from Resident #21 and observed RN #1 spoon feeding Resident #21 her medications.</p> <p>Resident #21's medical record did not document her wish to receive her medication in the dining room.</p> <p>3. On 12/3/24 at 8:19 AM, Resident #23 was observed sitting in the common area, waiting for her breakfast. Two other residents were sitting in the common area and observed RN #1 checking Resident #23's blood sugar.</p> <p>Resident 23's medical record did not document her wish to have her blood sugar checked in common areas.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. On 12/3/24 at 11:51 AM, Resident #18 was observed sitting in the activity room. There were 4 other residents in the activity room who observed RN #2 pulling Resident #18's sleeve up on her right arm and administering her insulin injection.</p> <p>Resident #18's medical record did not document her wish to receive her insulin in common areas.</p> <p>On 12/3/24 at 7:47 AM, RN #1 stated the facility conducts audits asking residents if they wanted their medications and blood sugar testing administered outside their rooms, and the residents had physician orders documenting the residents preferred their medications be given outside their rooms.</p> <p>On 12/4/24 at 11:49 AM, the DON stated there were no audits conducted to ensure residents had agreed to have their medications or blood sugars checked in common areas. She stated the residents should have orders that documented nurses may administer medications in a common area, and it should be on the resident's care plan.</p> <p>On 12/5/24 at 10:59 AM, the DON stated she did not have orders for Residents #1, #18, #21, or #23 to receive medications in common areas.</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51121</p> <p>Based on record review and staff interview, it was determined the facility failed to ensure a bed hold notice was provided to residents or their representatives at the time of the resident's transfer to the hospital. This was true for 1 of 12 residents (Resident #22) reviewed for transfers. This deficient practice created the potential for harm if residents were not informed of their right to return to their former bed or room at the facility within a specified time. Findings include:</p> <p>Resident #22 was admitted to the facility on [DATE], with multiple diagnoses including schizophrenia (a chronic mental disorder that affects a person's ability to think, perceive reality, and interact with others) and traumatic brain injury (a brain injury caused by an external force, such as a blow or jolt to the head).</p> <p>Resident #22's medical record documented she had been transferred to the hospital on 10/8/24, and returned to the facility on [DATE]. The facility bed hold document had not been completed until 10/15/24, 3 days after Resident #22 returned to the facility.</p> <p>On 12/4/24 at 2:40 PM, the DON stated the bed hold should have been completed at time of transfer to the hospital.</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49552</p> <p>Based on record review and staff interview, it was determined the facility failed to ensure the MDS assessment accurately reflected a resident's status. This was true for 3 of 12 residents (# 2, #14, and #33) whose MDS assessments were reviewed. This deficient practice had the potential for negative outcomes if the resident was not assessed and/or monitored due to inaccurate assessments. Findings include:</p> <p>1. Resident #2 was admitted to the facility on the 1/18/18, with multiple diagnoses including bipolar and hypertension.</p> <p>Resident #2's Quarterly MDS, dated [DATE], did not document she had a feeding tube (a small, flexible tube that provides a way to deliver nutrition through the stomach).</p> <p>Resident #2's Quarterly MDS, dated [DATE], documented she had a feeding tube.</p> <p>On 12/2/24 at 11:58 AM, RN #1 stated Resident #2 did not have a feeding tube.</p> <p>On 12/3/24 at 10:48 AM, the DON stated the feeding tube documented on Resident # 2's MDS was an error in reporting and should not have been on her MDS.</p> <p>2. Resident #14 was admitted to the facility on [DATE], with multiple diagnoses including psychotic disorder (a severe mental illness that causes a person to lose touch with reality and have abnormal perceptions and thoughts) and bipolar disease (a mental illness that causes extreme shifts in mood, energy, and activity levels).</p> <p>The Quarterly MDS dated [DATE], documented Resident #14 had an enteral feeding tube.</p> <p>On 12/2/24 at 9:00 AM, Resident #14 stated she did not have a feeding tube in place.</p> <p>On 12/4/24 at 2:59 PM, the DON stated Resident #14 has not had a feeding tube in place while at the facility.</p> <p>3. Resident #33 was admitted to the facility on [DATE], with multiple diagnoses including dementia and major depressive disorder.</p> <p>Resident #33's pharmacy Drug Regimen Review report documented she was on Risperidone (an antipsychotic) for psychosis.</p> <p>Resident #33's care plan, dated 1/30/24, documented she used psychotropic medications related to her disease process of dementia with behavioral disturbance and psychosis.</p> <p>Resident #33's Quarterly MDS, dated [DATE], Section I - Active Diagnoses, documented she had major depressive disorder and depression. Psychiatric disorder (including dementia with behavior disturbances) was not documented on Resident #33's Quarterly MDS. Resident #33 did not have a psychosis diagnosis documented on her Quarterly MDS.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/5/24 at 11:39 AM, the DON stated the doctor had not updated Resident #33's medication list and therefore the Quarterly MDS was wrong. She further stated Resident #33's Quarterly Assessment should have included her diagnosis of psychosis.</p> <p>51121</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51121</p> <p>Based on observation, record review, and staff interview, it was determined the facility failed to ensure resident's care plans were revised to reflect current physician orders. This was true for 1 of 12 residents (Resident #10) whose care plans were reviewed. This placed residents at risk of adverse outcomes if care and services had been provided that were not ordered by the physician. Findings include:</p> <p>Resident #10 was admitted to the facility on [DATE], with multiple diagnoses including schizoaffective disorder depressive type (a mental illness that involves a combination of schizophrenia symptoms and depressive episodes) and rotator cuff tear (a tear in the muscles and tendons that surround the shoulder joint).</p> <p>On 12/3/24, Resident #10's care plan, initiated on 9/10/24, documented Resident #10 was to be given spironolactone (an anti-hypertensive medication) however, this medication was not listed in Resident #10's active or discontinued medication orders.</p> <p>On 12/4/24 at 1:50 PM, the DON stated Resident #10 was not receiving spironolactone and her care plan should have been updated to remove that medication.</p>		

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<p>F 0676</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49552</p> <p>Based on observation, record review, and staff interview, it was determined the facility failed to ensure residents were given treatment and services to maintain or improve their ability to carry out activities of daily living (ADLs). This was true for 2 of 10 residents (#8 and #18) reviewed for decline in ADLs without services. This failure placed residents at risk for decreased range of motion, functional ability, and decreased quality of life. Findings include:</p> <p>1. Resident #8 was admitted [DATE], with multiple diagnoses including schizophrenia and diabetes.</p> <p>Resident #8's Quarterly MDS, dated [DATE], section GG, documented no impairment to UE or LE.</p> <p>Resident #8's State optional MDS, dated [DATE], section G documented Independent with bed mobility, transfers, and toileting.</p> <p>Resident #8's Quarterly MDS, dated [DATE], section GG, documented bilateral lower extremities impairment. No impairment to bilateral upper extremities.</p> <p>Resident #8's State optional MDS, dated [DATE], section G, documented limited assistance with bed mobility, limited assistance with transfers, and extensive assistance with toileting.</p> <p>Resident #8's medical record did not document she received restorative nursing services or had declined restorative services.</p> <p>On 12/3/24 at 3:30 PM, the DON stated they did not have a restorative program.</p> <p>On 12/5/24 at 11:43 AM, the DON stated there was no documentation by staff documenting something had been done to prevent decline in Resident #8's ADLs.</p> <p>2. Resident #18 was admitted to the facility on [DATE], with multiple diagnoses including schizoaffective disorder bipolar type (a rare mental illness that occurs when someone experiences both schizophrenia and bipolar disorder symptoms at the same time) and polyneuropathy (a disease that occurs when many peripheral nerves in the body malfunction at the same time).</p> <p>Resident #18's Quarterly MDS assessments documented her decline in ADLs as follows:</p> <p>On 1/30/24, the MDS documented no impairment for upper or lower extremities and resident was using both walker and wheelchair.</p> <p>On 4/23/24, the MDS documented no impairment for upper extremities, impairment for both sides of lower extremities, and resident only using wheelchair.</p> <p>(continued on next page)</p>		

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<p>F 0676</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/16/24, the MDS documented impairment on both upper and lower extremities, resident only using wheelchair. Related to resident mobility, resident lying to sitting on side of bed, helper does more than half the effort, resident sitting on side of bed to lying, helper does more than half the effort.</p> <p>On 10/1/24, the MDS documented related to resident mobility, resident lying to sitting on side of bed, helper does all the effort, resident sitting on side of bed to lying, helper does all the effort.</p> <p>A review of Resident #18's record identified the following orders and treatments related to her ADL decline:</p> <p>On 9/5/24, Resident #18's physician discontinued physical therapy.</p> <p>A physician order, dated 9/10/24, documented restorative nursing for general muscle strengthening, stamina, and active range of motion (AROM), 30 minutes daily, 6 to 7 days a week.</p> <p>Resident #18's care plan, initiated 9/26/24, directed staff to perform restorative nursing for general muscle strengthening, stamina, and AROM. 30 minutes per episode.</p> <p>On 9/14/24, a CNA documented 15 minutes of range of motion (ROM) was performed for Resident #18.</p> <p>On 9/16/24, a CNA documented resident refused treatment that day, stating, she can't do it, now that [Physical Therapist] was gone.</p> <p>On 12/3/24 at 12:12 PM, Resident #18 stated since the Physical Therapist left a few months ago she had not participated in any physical therapy and she felt her abilities and strength had declined. When asked if she wanted restorative nursing services after her physical therapy was discontinued, she stated, yes.</p> <p>On 12/3/24, 4:18 PM documentation was requested related to restorative nursing care being offered or provided to Resident #18, the DON stated there was none other than the CNA documentation on 9/14/24 and 9/16/24 .</p> <p>On 12/4/24 at 2: 32 PM, the DON confirmed Resident #18 had not received restorative services, as ordered, and her decline of strength had been occurring for a period of time.</p> <p>51121</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51121</p> <p>Based on observation, record review, and interview, it was determined the facility failed to ensure care plans were followed. This was true for 1 of 12 residents (Resident #9) whose care plans were reviewed. This had the potential for adverse effects and possible harm to resident's medical and physical status. Findings include:</p> <p>Resident #9 was admitted to the facility on [DATE], with multiple diagnoses including schizoaffective disorder bipolar type (a rare mental illness that occurs when someone experiences both schizophrenia and bipolar disorder symptoms at the same time) and chronic obstructive pulmonary disease (a common lung disease causing restricted airflow and breathing problems).</p> <p>Resident #9's care plan, initiated on 10/17/24, directed CNAs and licensed nursing staff to keep oxygen saturations at 90% and licensed nursing staff are to contact the physician with decreased pulse oximetry.</p> <p>The following oxygen saturation checks below 90% were documented:</p> <p>10/21/24 at 8:47 AM, SpO2 89%, obtained by CNA #1</p> <p>10/26/24 at 10:03 AM, SpO2 89%, obtained by CNA #2</p> <p>10/27/24 at 10:10 AM, SpO2 89%, obtained by CNA #3</p> <p>10/31/24 at 9:34 AM, SpO2 84%, obtained by CNA #4</p> <p>11/10/24 at 9:49 AM, SpO2 86%, obtained by CNA #2</p> <p>11/15/24 at 2:46 PM, SpO2 84%, obtained by CNA #5</p> <p>11/17/24 at 10:03 AM, SpO2 81%, obtained by CNA #6</p> <p>11/18/24 at 12:20 AM, SpO2 86%, obtained by CNA #7</p> <p>11/22/24 at 9:49 AM, SpO2 80%, obtained by CNA #8</p> <p>Resident #9's medical record did not include documentation licensed nursing staff notified his physician.</p> <p>On 12/4/24 at 2:58 PM, the DON stated the CNAs documented the oxygen saturation information and had not notified the licensed nursing staff of the low oxygen level and should have.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51121</p> <p>Based on observation, interview, policy review, and U.S. Food and Drug Administration 2022 Food Code, the kitchen staff failed to appropriately store and label foods and wash hands prior to donning gloves. This deficient practice had the potential to affect all residents who received meals prepared in the facility's kitchen. Findings include:</p> <p>1. U.S. Food and Drug Administration 2022 Food Code documented: Annex ,d+[DATE].15 documented hands must be washed before donning gloves.</p> <p>On [DATE] at 7:40 AM, observed a senior cook leave the serving line area to thin out puree with her gloves on and returned to the serving line area with gloves on. She then removed gloves but she did not wash hands before redonning gloves.</p> <p>On [DATE] at 8:00 AM, the Dietary Manager stated the senior cook should have washed her hands after doffing gloves and donning new gloves.</p> <p>2. U.S. Food and Drug Administration 2022 Food Code documented: ,d+[DATE].17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under S ,d+[DATE].12, and except as specified in (E) and (F) of this section, refrigerated, READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1.</p> <p>On [DATE] at 7:05 AM, observed the following expired foods in the walk-in refrigerator:</p> <ul style="list-style-type: none"> - cut up lettuce in a plastic bag with use by date of ,d+[DATE], - a container with ranch dressing with expired date of ,d+[DATE], - a container of pineapple juice with use by date of ,d+[DATE]. <p>On [DATE] at 7:08 AM, the Dietary Manager stated these expired food items should have been removed from the walk-in refrigerator.</p> <p>3. The facility policy Refrigerated Food Storage, dated [DATE], documented under III. Procedure, A,2,b. Nursing staff will discard any food items that are marked with a date five (5) days prior to the current date or longer.</p> <p>On [DATE] at 2:24 PM, observed the following expired food items in the resident refrigerator:</p> <ul style="list-style-type: none"> - Opened salsa with resident name and opened date of [DATE]. - Opened mayonnaise with resident name and opened date of [DATE], expired date [DATE]. <p><i>(continued on next page)</i></p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- Opened French Onion Dip with resident name and opened date of [DATE].</p> <p>- Opened Watermelon Minute Maid with resident name and opened date of [DATE] and expired date of [DATE].</p> <p>On [DATE] at 3:10 PM, the DON stated those expired food items in the resident refrigerator should have been thrown away.</p>		

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Dispose of garbage and refuse properly.</p> <p>51121</p> <p>Based on observation, interview, Department of Health and Welfare - Idaho Administrative rules, and U.S. Food and Drug Administration 2022 Food Code review, the facility failed to ensure garbage cans were properly closed with lids to minimize attracting pests and rodents into the kitchen. This deficient practice had the potential to affect all residents and staff in the facility. Findings include:</p> <p>Department of Health and Welfare - Idaho Administrative Rules 16.03.02. Environmental Sanitation 108. Garbage and Refuse 03a. All containers used for storage of garbage and refuse shall be constructed of durable, nonabsorbent material and shall not leak or absorb liquids. Containers shall be provided with tight-fitting lids unless stored in vermin-proof rooms or enclosures, or in a waste refrigerator.</p> <p>U.S. Food and Drug Administration 2022 Food Code, 5-501.113 Covering Receptacles. Receptacles and waste handling units for REFUSE, recyclables, and returnables shall be kept covered: (A) Inside the FOOD ESTABLISHMENT if the receptacles and units: (1) Contain FOOD residue and are not in continuous use; or (2) After they are filled.</p> <p>On 12/2/24 at 8:04 AM, observed five uncovered garbage cans in the kitchen and food serving area without closing lids.</p> <p>On 12/4/24 at 9:25 AM, the Dietary Manager stated she was not aware the garbage cans had to have closing lids on them.</p>		