



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

February 5, 2015

Robert Nahmensen, Administrator
Good Samaritan Society-- Silver Wood Village
PO Box 358
Silverton, ID 83867-0358

Provider #: 135058

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

Dear Mr. Nahmensen:

On **January 27, 2015**, a Facility Fire Safety and Construction survey was conducted at **Good Samaritan Society - Silver Wood Village** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. Please provide **ONLY ONE** completion date for each federal and state tag in column (X5) Completion Date to signify when you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on

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page 2). After each deficiency has been answered and dated, the administrator should sign both Statement of Deficiencies and Plan of Correction, Form CMS-2567 and State Form, in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **February 18, 2015**. Failure to submit an acceptable PoC by **February 18, 2015**, may result in the imposition of civil monetary penalties by **March 10, 2015**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.
- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567 and the state licensure survey report, State Form.

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **February 24, 2015**, (Opportunity to Correct). Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **February 24, 2015**. A change in the seriousness of the deficiencies on **February 24, 2015**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **February 24, 2015**, includes the following:

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Denial of payment for new admissions effective **April 27, 2015**.
42 CFR §488.417(a)

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **July 27, 2015**, if substantial compliance is not achieved by that time.

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

If you believe these deficiencies have been corrected, you may contact Mark P. Grimes, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **January 27, 2015**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

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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 **February 18, 2015**. If your request for informal dispute resolution is received after **February 18, 2015**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



Mark P. Grimes, Supervisor
Facility Fire Safety and Construction

MPG/lj
Enclosures

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

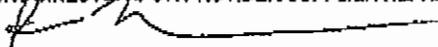
 Printed: 02/04/2015
 FORM APPROVED
 OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135058	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 01/27/2015
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - SILVER WOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 406 WEST SEVENTH STREET SILVERTON, ID 83867		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The facility is a single story, type V (III) fully sprinklered structure built in 1975. A complete fire alarm system is in place. There is an assisted living wing with adjacent independent retirement wing with a two (2) hour fire wall separation between assisted living/skilled nursing and independent. The facility is currently licensed for 50 beds. The following deficiencies were cited during the annual life safety code survey conducted on January 27, 2015. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70. The survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction	K 000	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the state operations manual.	
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This Standard is not met as evidenced by:	K 029	1. Doors to these areas will be self-closing and the pass through door will be sealed. 2. This deficiency affected staff and 34 residents.	

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

TITLE

(X6) DATE



Administrator

2-18-15

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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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - SILVER WOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 405 WEST SEVENTH STREET SILVERTON, ID 83867		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	<p>Continued From page 1</p> <p>Based on observation, operational testing and interview, the facility failed to ensure that hazardous areas were protected with self-closing doors. Failure of hazardous area doors to self-close would allow smoke and dangerous gases to pass into corridors affecting safe egress. This deficient practice affected 4 residents in the 100 wing, residents utilizing the main dining facility, staff and visitors on the date of the survey. The facility is licensed for 50 SNF/NF beds and had a census of 34 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on January 27, 2014 from 1:00 PM to 3:30 PM, observation of the pass-through door into the Kitchen; the main door leading from the dining hall into the dishwashing area of the Kitchen and the door leading into the Housekeeping storage in the 100 wing found they would not self-close.</p> <p>Further observation of these areas found the pass through door was only equipped with a rope and pulley system to close the drop-down door; The Housekeeping storage area measured approximately nine feet by twelve feet (108 sf.) and housed paper products, chemicals and bulk storage of alcohol-based hand rub refills and the dishwashing area door was not equipped to self-close and equipped with a drop-down hold open device. Interview of the Maintenance Supervisor found he was not aware these doors were required to self-close.</p> <p>Actual NFPA standard:</p> <p>NFPA 101 3.3.13.2 Area, Hazardous.</p>	K 029	<ol style="list-style-type: none"> 3. Self-closing devices have been installed on the door leading into the dishwashing area and housekeeping door and the pass through door into the kitchen has been sealed off. 4. A preventive maintenance schedule will be implemented for the inspection of doors to hazardous areas to ensure the deficiency practice does not reoccur. Maintenance staff will be educated on the new PM schedule. 5. Corrective action will be completed by February 12, 2015. 	

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - SILVER WOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 405 WEST SEVENTH STREET SILVERTON, ID 83867
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K 029	<p>Continued From page 2</p> <p>An area of a structure or building that poses a degree of hazard greater than that normal to the general occupancy of the building or structure, such as areas used for the storage or use of combustibles or flammables; toxic, noxious, or corrosive materials; or heat-producing appliances.</p> <p>19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:</p> <ol style="list-style-type: none"> (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft² (9.3 m²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft² (4.6 m²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. <p>Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more</p>	K 029		

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - SILVER WOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 405 WEST SEVENTH STREET SILVERTON, ID 83867		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 3 than 48 in. (122 cm) above the bottom of the door. 19.2.2.2.6* Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier, or hazardous area enclosure shall be permitted to be held open only by an automatic release device that complies with 7.2.1.8.2. The automatic sprinkler system, if provided, and the fire alarm system, and the systems required by 7.2.1.8.2 shall be arranged to initiate the closing action of all such doors throughout the smoke compartment or throughout the entire facility.	K 029		
K 062 SS*E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.6 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that sprinkler heads had been maintained as required after a change in the facility structure. A condition of mixed heads may not adequately respond at the correct temperature allowing fires to grow beyond incipient stages. This deficient practice affected staff and visitors engaged in the Laundry services on the date of the survey. The facility is licensed for 50 SNF/NF beds and had a census of 34 on the day of the survey. Findings include: During the facility tour conducted on January 27,	K 062	K062 1. Sprinkler heads will be maintained and updated to current fire safety standards. 2. This deficiency affected staff and visitors in the laundry service area. 3. In-adequate sprinkler heads have been replaced to match others within the area. 4. A preventive maintenance schedule will be implemented for inspection of sprinkler heads to ensure uniformity within compartmental spaces. Maintenance staff will be educated on the new PM schedule. 5. Corrective action will be completed by February 12, 2015	

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - SILVER WOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 405 WEST SEVENTH STREET SILVERTON, ID 83867		
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K 062	Continued From page 4 2015 from 1:00 PM to 3:30 PM, observation of the sprinkler heads in the Laundry found them to be a mix of ordinary and standard response. Interview of the Maintenance Supervisor found that a remodel of the Laundry room removed a wall which had previously separated the room and also separated the sprinkler heads. Actual NFPA standard: NFPA 13 5-3.1.5.2 When existing light hazard systems are converted to use quick-response or residential sprinklers, all sprinklers in a compartmented space shall be changed.	K 062		
K 064 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure fire extinguishers were installed in accordance with NFPA 10. Failure to provide fire extinguishers at the correct height could limit the ability to contain incipient fires. This deficient practice affected 34 residents, staff and visitors on the date of the survey. The facility is licensed for 50 SNF/NF beds and had a census of 34 on the day of the survey. Findings include: During the facility tour conducted on January 27,	K 064	K 064 1. Fire extinguishers within the facility will be replaced with 5lb fire extinguishers. 2. This deficiency would affect staff and 34 residents. 3. The fire extinguishers throughout the facility have been updated replacing the 10lb extinguishers with 5 lb. extinguishers within the containment boxes to assure correct height.	

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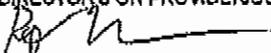
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - SILVER WOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 405 WEST SEVENTH STREET SILVERTON, ID 83867		
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K 064	<p>Continued From page 5</p> <p>2015 from 1:00 PM to 3:30 PM, observation of the fire extinguishers installed in the facility found that four (4) of those installed in the corridors measured above 60 inches to the top of the extinguisher. Interview of the Maintenance Supervisor found he was not aware of the height requirement for the installation of extinguishers.</p> <p>Actual NFPA standard:</p> <p>NFPA 10 1-6.10 Fire extinguishers having a gross weight not exceeding 40 lb (18.14 kg) shall be installed so that the top of the fire extinguisher is not more than 5 ft (1.53 m) above the floor. Fire extinguishers having a gross weight greater than 40 lb (18.14 kg) (except wheeled types) shall be so installed that the top of the fire extinguisher is not more than 3 1/2 ft (1.07 m) above the floor. In no case shall the clearance between the bottom of the fire extinguisher and the floor be less than 4 in. (10.2 cm).</p>	K 064	<p>4. A preventive maintenance schedule will be implemented for inspection of fire extinguishers to ensure they are the proper weight. Maintenance staff will be educated on the new PM schedule.</p> <p>5. Corrective action will be completed by February 12, 2015.</p>		

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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135058	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 01/27/2015
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - SILVER WOOD VILL		STREET ADDRESS, CITY, STATE, ZIP CODE 408 WEST SEVENTH STREET SILVERTON, ID 83867		
(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)	(X6) COMPLETE DATE
C 000	16.03.02 INITIAL COMMENTS The facility is a single story, type V (III) fully sprinklered structure built in 1975. A complete fire alarm system is in place. There is an assisted living wing with adjacent independent retirement wing with a two (2) hour fire wall separation between assisted living/skilled nursing and independent. The facility is currently licensed for 50 beds. The following deficiencies were cited during the annual life safety code survey conducted on January 27, 2015. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70 and IDAPA 16.03.02, Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities. The survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction	C 000		
C 226	02.106 FIRE AND LIFE SAFETY 106. FIRE AND LIFE SAFETY. Buildings on the premises used as facilities shall meet all the requirements of local, state and national codes concerning fire and life safety standards that are applicable to health care facilities. This Rule is not met as evidenced by: Please refer to federal "K" tags on CMS 2567:	C 226	See POC for K029, K062, K064	

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



TITLE

Administrator

(X6) DATE

2/10/15

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135058	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 01/27/2015
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C 226	Continued From Page 1 K-029 Hazardous areas K-062 Sprinkler maintenance K-064 Fire extinguisher installations	C 226		