



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

May 20, 2015

Brian Davidson, Administrator
Good Samaritan Society-- Boise Village
3115 Sycamore Drive
Boise, ID 83703-4129

Provider #: 135085

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Mr. Davidson:

On **May 11, 2015**, a Facility Fire Safety and Construction survey was conducted at **Good Samaritan Society-- Boise 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 **June 2, 2015**. Failure to submit an acceptable PoC by **June 2, 2015**, may result in the imposition of civil monetary penalties by **June 22, 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 **June 15, 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 **June 15, 2015**. A change in the seriousness of the deficiencies on **June 15, 2015**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **June 15, 2015**, includes the following:

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Denial of payment for new admissions effective **August 11, 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 **November 11, 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 **May 11, 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 **June 2, 2015**. If your request for informal dispute resolution is received after **June 2, 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,

A handwritten signature in black ink, appearing to read 'MPG', followed by a long horizontal line extending to the right.

Mark P. Grimes, Supervisor
Facility Fire Safety and Construction

MPG/lj
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135085	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE BLDG B. WING _____	(X3) DATE SURVEY COMPLETED 05/11/2015
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - BOISE VILLAG	STREET ADDRESS, CITY, STATE, ZIP CODE 3115 SYCAMORE DRIVE BOISE, ID 83703
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(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
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K 000	<p>INITIAL COMMENTS</p> <p>The facility is a single story, type V(111) construction with multiple additions and renovations. The most recent addition was completed in 2002 on the West side. A new complete fire alarm/smoke detection system was installed in 2001. The facility was originally built in 1957 and is fully sprinklered with the oldest portion of the building being demolished in 2007. Currently it is licensed for 127 SNF/NF beds.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on May 11, 2015. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.</p> <p>The Survey was conducted by:</p> <p>Nathan Elkins Health Facility Surveyor Fire Life Safety & Construction</p>	K 000	<p>General Disclaimer</p> <p>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.</p>	
K 012 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure the fire and smoke resistive integrity of the building. Failure to ensure the smoke and fire resistive properties of the facility could allow smoke and dangerous gases to pass freely and add to the rapid development of fire in exposed wall cavities. This deficient practice</p>	K 012	<p>K 012</p> <p>Resident Specific</p> <p>The failure to ensure the fire and smoke resistive integrity of the building had the potential to affect all residents, staff, and visitors on the date of the survey.</p> <p>Other Residents</p> <p>The failure to ensure the fire and smoke resistive integrity of the</p>	6/2/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE ADMINISTRATOR	(X6) DATE 5/29/15
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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 - BOISE VILLAG		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 SYCAMORE DRIVE BOISE, ID 83703		
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K 012	<p>Continued From page 1</p> <p>could potentially affect all residents, staff and visitors on the date of the survey. The facility is licensed for 127 SNF/NF beds and had a census of 95 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour on May 11, 2015 at approximately 10:30 AM, observation of the Dietary Supplies room found a 1 inch conduit piping penetrating through a 3 inch hole in the wall exposing the interior wall cavity eliminating the 1-hour rating of the wall. It was also discovered the 1 inch conduit piping penetrated through a 2 inch hole in the ceiling tile would allow the passage of smoke . When asked, the Administrator stated they were unaware of the open penetrations.</p> <p>Actual NFPA standard: 19.1.6.2 Health care occupancies shall be limited to the types of building construction shown in Table 19.1.6.2. (See 8.2.1.) Exception*: Any building of Type I(443), Type I(332), Type II(222), or Type II(111) construction shall be permitted to include roofing systems involving combustible supports, decking, or roofing, provided that the following criteria are met: (a) The roof covering meets Class C requirements in accordance with NFPA 256, Standard Methods of Fire Tests of Roof Coverings. (b) The roof is separated from all occupied portions of the building by a noncombustible floor assembly that includes not less than 2 1/2 in. (6.4 cm) of concrete or gypsum fill. (c) The attic or other space is either unoccupied or protected throughout by an approved</p>	K 012	<p>building has the potential to affect all residents, staff, and visitors.</p> <p>Facility System</p> <p>The open penetrations in the wall and ceiling of the dietary supply room were sealed with a fire and smoke resistive barrier on 5/12/15.</p> <p>The Director of Environmental Services has inspected all penetrations to ensure the fire and smoke resistive integrity of the building. Any issues found were corrected with fire and smoke resistive barrier.</p> <p>Weekly inspections x4, bi-weekly inspections x2, and monthly inspections x4 will be completed by the Director of Environmental Services to ensure proper fire and smoke resistive integrity of the building.</p> <p>Quality Assurance and Monitoring</p> <p>The Director of Environmental Services will report any findings to the Quality Assurance and Performance Improvement (QAPI) meeting for further monitoring and plan modification if compliance is not met.</p>	

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K 012	Continued From page 2 automatic sprinkler system. 8.2.1* Construction. Buildings or structures occupied or used in accordance with the individual occupancy chapters (Chapters 12 through 42) shall meet the minimum construction requirements of those chapters. NFPA 220, Standard on Types of Building Construction, shall be used to determine the requirements for the construction classification. Where the building or facility includes additions or connected structures of different construction types, the rating and classification of the structure shall be based on either of the following: (1) Separate buildings if a 2-hour or greater vertically-aligned fire barrier wall in accordance with NFPA 221, Standard for Fire Walls and Fire Barrier Walls, exists between the portions of the building Exception: The requirement of 8.2.1(1) shall not apply to previously approved separations between buildings. (2) The least fire-resistive type of construction of the connected portions, if no such separation is provided	K 012	<i>Date of compliance</i> June 2, 2015 <u>K 062</u> <i>Resident Specific</i> The failure to ensure fire sprinkler heads are maintained in proper operating condition had the potential to affect 29 residents, staff and visitors on the date of survey. <i>Other Residents</i> The failure to ensure that fire sprinkler heads are maintained in proper operating condition has the potential to affect all residents, staff and visitors. <i>Facility System</i> The sprinkler head in the closet of room 212 was replaced on 5/21/15 by All Valley Fire. A complete audit of all sprinkler heads was completed by the Director of Environmental Services to ensure they are in proper operating condition. Weekly inspections x4, bi-weekly inspections x2, and monthly inspections x4 will be completed	6/2/15
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, 9.7.5 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that fire sprinkler heads are maintained in proper operating condition. Failure	K 062		

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K 062	Continued From page 3 to maintain sprinkler heads could affect the water distribution patterns, delay operations, or render the sprinkler inoperable. This deficient practice affected one of nine smoke compartments, 29 residents, staff and visitors on the date of survey. The facility is licensed for 127 SNF/NF beds with a census of 95 on the day of survey. Findings include: During the facility tour on May 11, 2015 at approximately 11:00 AM, observation of the closet in room 212 revealed an upright mounted fire sprinkler head had been painted. When asked, the Administrator stated the facility was unaware of the painted sprinkler head. Actual NFPA reference: NFPA 25 2-2.1 Sprinklers. 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. Exception No. 1*: Sprinklers installed in concealed spaces such as above suspended ceilings shall not require inspection. Exception No. 2: Sprinklers installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown	K 062	by the Director of Environmental Services to ensure all sprinkler heads are in proper operating condition. Any sprinkler heads found not to be in proper operating condition will be replaced. Quality Assurance and Monitoring The Director of Environmental Services will report any findings to the Quality Assurance and Performance Improvement (QAPI) meeting for further monitoring and plan modification if compliance is not met. Date of compliance June 2, 2015	
K 130 SS=F	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786	K 130	K 130 Resident Specific The failure to ensure doors protecting corridor openings close and latch properly had the potential to affect all residents, staff, and visitors on the date of survey. Other Residents The failure to ensure doors	6/2/15

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K 130	Continued From page 4 This Standard is not met as evidenced by: Based on observation, operational testing and interview it was determined that the facility did not ensure doors protecting corridor openings closed and latched properly. Failure to provide effective self closing doors can allow smoke and fire gases to rapidly spread into the corridors. This deficient practice could potentially affect all residents, staff, and visitors on the day of survey. The facility is licensed for 127 SNF/NF beds with a census of 95 on the date of survey. Findings include: During the tour of the facility on May 11, 2015, at approximately 1:30 PM, observation and operational testing of the MDS office revealed the door would not close and latch when released from the magnetic hold open device. When asked, the Administrator stated he was unaware of the door not closing and latching properly. LSC 101 4.5.7 Maintenance. Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be maintained unless the Code exempts such maintenance.	K 130	protecting corridor openings close and latch properly has the potential to affect all residents, staff, and visitors. Facility System The MDS office door was repaired on 5/12/15 and now properly closes and latches. An inspection of all doors protecting corridor openings has been completed by the Director of Environmental Services to ensure they properly close and latch. Any doors found not to be in proper operating condition were repaired and/or adjusted. Weekly inspections x4, bi-weekly inspections x2, and monthly inspections x4 will be completed by the Director of Environmental Services to ensure doors protecting corridor openings close and latch properly. Any doors found not to be in proper operating condition will be repaired and/or adjusted.	
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	K 147	Quality Assurance and Monitoring The Director of Environmental Services will report any findings to the Quality Assurance and Performance Improvement (QAPI)	

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K 147	<p>Continued From page 5</p> <p>This Standard is not met as evidenced by: Based on observation and interview the facility did not ensure that electrical wiring was in accordance with NFPA 70. Utilizing relocatable power taps and extension cords improperly can lead to overload wiring and start a fire. The deficient practice affected two of nine smoke compartments, 14 residents, staff and visitors on the date of survey. The facility is licensed for 127 SNF/NF beds with a census of 95 on day of survey.</p> <p>Findings include:</p> <p>1.) During the facility tour on May 11, 2015 between 9:30 AM and 1:30 PM, observation of the Food Services Office revealed two (2) Relocatable Power Taps (RPT) that were series connected (daisy chained) with each other powering computer equipment. When asked, the Administrator stated he was unaware that two (2) Relocatable Power Taps were series connected.</p> <p>2.) During the facility tour on May 11, 2015 between 9:30 AM and 1:30 PM, observation of room #508 revealed an oxygen concentrator and a Nebulizer plugged into a Relocatable Power Tap (RPT). When asked, the Maintenance Supervisor stated he was unaware of the medical equipment plugged into the Relocatable Power Tap (RPT).</p> <p>Actual NFPA reference: NFPA 70 National Electrical Code 1999 Edition 400-8. Uses Not Permitted Unless specifically permitted in Section 400-7, flexible cords and cables shall not be used for the following: 1. As a substitute for the fixed wiring of a</p>	K 147	<p>meeting for further monitoring and plan modification if compliance is not met.</p> <p><i>Date of compliance</i></p> <p>June 2, 2015</p> <p><u>K 147</u></p> <p><i>Resident Specific</i></p> <p>The failure to ensure that electrical wiring was in accordance with NFPA 70 had the potential to affect two of nine smoke compartments, 14 residents, staff and visitors on the date of survey.</p> <p><i>Other Residents</i></p> <p>The failure to ensure that electrical wiring was in accordance with NFPA 70 has the potential to affect all residents, staff and visitors.</p> <p><i>Facility System</i></p> <p>1.) The Director of Environmental Services removed one of the Relocatable Power Taps so there is no longer a series connected situation in the Food Services Office.</p>	6/2/15

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K 147	Continued From page 6 structure 2. Where run through holes in walls, structural ceilings suspended ceilings, dropped ceilings, or floors 3. Where run through doorways, windows, or similar openings 4. Where attached to building surfaces Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of Section 364-8. 5. Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors 6. Where installed in raceways, except as otherwise permitted in this Code See UL listings: XBYS Guide information XBZN2 Guide information	K 147	2.) The Oxygen concentrator and Nebulizer were plugged directly into the wall outlet in Room 508. The Director of Environmental Services completed an inspection of all resident rooms and offices to ensure Relocatable Power Taps are being properly used. An electrician was hired to install additional wall plug-ins as needed. Weekly inspections x4, bi-weekly inspections x2, and monthly inspections x4 will be completed by the Director of Environmental Services to ensure Relocatable Power Taps are being used in accordance with NFPA 70. Quality Assurance and Monitoring The Director of Environmental Services will report any findings to the Quality Assurance and Performance Improvement (QAPI) meeting for further monitoring and plan modification if compliance is not met. Date of compliance June 2, 2015	