



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

November 5, 2015

Jamie Berg, Administrator
Good Samaritan Society-- Moscow Village
640 North Eisenhower Street
Moscow, ID 83843-9588

Provider #: 135067

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

Dear Ms. Berg:

On **October 29, 2015**, a Facility Fire Safety and Construction survey was conducted at **Good Samaritan Society-- Moscow 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. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. Please provide **ONLY ONE** completion date for each federal and state tag in column (X5) Completion Date to signify when

Jamie Berg, Administrator
November 5, 2015
Page 2 of 4

you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office. If a State Form with deficiencies was issued, it should be signed, dated and returned along with the CMS-2567 Form.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **November 18, 2015**. Failure to submit an acceptable PoC by **November 18, 2015**, may result in the imposition of civil monetary penalties by **December 8, 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 **December 3, 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 **December 3, 2015**. A change in the seriousness of the deficiencies on **December 3, 2015**, may result in a change in the remedy.

Jamie Berg, Administrator
November 5, 2015
Page 3 of 4

The remedy, which will be recommended if substantial compliance has not been achieved by **December 3, 2015**, includes the following:

Denial of payment for new admissions effective **January 29, 2016**.
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 **April 29, 2016**, 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 **October 29, 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:

Jamie Berg, Administrator
November 5, 2015
Page 4 of 4

<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:

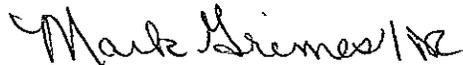
BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process
2001-10 IDR Request Form

This request must be received by **November 18, 2015**. If your request for informal dispute resolution is received after **November 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: 11/04/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135067	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/29/2015
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - MOSCOW VILL		STREET ADDRESS, CITY, STATE, ZIP CODE 640 NORTH EISENHOWER STREET MOSCOW, ID 83843	
(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	<p>INITIAL COMMENTS</p> <p>The facility is a single story, Type II(111) building with a two hour horizontal exit separation from the independent apartment complex. The building was built in 1975 and is fully sprinklered. Currently, the facility is licensed for 64 SNF/NF beds.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on October 29, 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>Nate Elkins Health Facility Surveyor Facility Fire Safety & Construction</p>	K 000	<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 025 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that smoke barriers were</p>	K 025	<p>K 025 SS=E</p> <ol style="list-style-type: none"> Both holes in the smoke barriers were resealed on October 29, 2015. All smoke barrier walls will be audited to ensure that no holes are present. A preventive maintenance plan will be developed to audit the smoke barrier walls quarterly. The Maintenance Director or designee will audit the smoke barrier walls quarterly x 2. All audit findings will be reported to QA/CQI for further monitoring and modification. Corrective action will be completed on or before December 3, 2015. <p>12-3-15</p>

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

Jan Berg

TITLE

Administrator

(X6) DATE

11-17-15

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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K 025	<p>Continued From page 1</p> <p>maintained. Failure to maintain smoke barriers could allow smoke and dangerous gases to pass freely between smoke compartments affecting egress and initiating system performance during a fire event. This deficient practice affected 21 residents, staff and visitors on the date of the survey. The facility is licensed for 64 SNF/NF beds with a census of 51 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour on October 29, 2015 at approximately 3:00 PM, observation of the the smoke barrier wall above the cross corridor doors in the 200 hallway revealed two unsealed holes approximately 2 inches in size penetrating through the wall. When asked, the Maintenance Supervisor stated the facility was unaware of the unsealed penetrations in the ceiling. This finding was acknowledged by Maintenance Supervisor and the Administrator at the exit conference.</p> <p>Actual NFPA standard:</p> <p>19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour. Exception No. 1: Where an atrium is used, smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with Exception No. 2 to 8.2.5.6(1). Not less than two separate smoke compartments shall be provided on each floor. Exception No. 2*: Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems where an approved, supervised automatic sprinkler system in accordance with</p>	K 025		

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K 025	<p>Continued From page 2</p> <p>19.3.5.3 has been provided for smoke compartments adjacent to the smoke barrier.</p> <p>8.3.2* Continuity. Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces. Exception: A smoke barrier required for an occupied space below an interstitial space shall not be required to extend through the interstitial space, provided that the construction assembly forming the bottom of the interstitial space provides resistance to the passage of smoke equal to that provided by the smoke barrier.</p> <p>K 062 NFPA 101 LIFE SAFETY CODE STANDARD SS=D</p> <p>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</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to maintain the components of the sprinkler heads. Failure to ensure that sprinkler heads are properly maintained would allow an ineffective spray pattern of the sprinkler head when activated and allow smoke and fire to spread rapidly. This deficient practice affected 1 of 6 smoke compartments and staff utilizing the storage room on the date of the survey. The facility is licensed for 64 SNF/NF beds with a</p>	K 025	<p>K 062 SS=D</p> <ol style="list-style-type: none"> The sprinkler head in the Physical Therapy Storage room was repaired on October 29, 2015. All sprinkler heads will be audited for damage. A preventive maintenance plan will be developed to audit the sprinkler heads semi-annually. The Maintenance Director or designee will audit the sprinkler heads. All audit findings will be reported to QA/CQI for further monitoring and modification. Corrective action will be completed on or before December 3, 2015. 	12-3-15

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K 062	<p>Continued From page 3 census of 51 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour on October 29, 2015 at approximately 12:00 PM, observation of the sprinkler head located in the Physical Therapy storage room appeared to be damaged. When asked, the Maintenance Supervisor stated the facility was unaware of the damaged sprinkler head. This finding was acknowledged by the Maintenance Supervisor and the Administrator at the exit conference.</p> <p>Actual NFPA standards:</p> <p>NFPA 101 4.6.12 Maintenance and Testing. 4.6.12.1 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 continuously maintained in accordance with applicable NFPA requirements or as directed by the authority having jurisdiction.</p> <p>NFPA 25 2-2 Inspection. 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.</p>	K 062	
(X5) COMPLETION DATE			

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K 144	<p>Continued From page 5</p> <p>reports revealed no documentation stating the load percentage of the generator when tested. When asked, the Maintenance Supervisor stated the facility was unaware of the load requirement and was unaware the documentation was not being recorded correctly. This finding was acknowledged by the Maintenance Supervisor and the Administrator at the exit conference.</p> <p>Actual NFPA Standard:</p> <p>NFPA 110, 6-4 Operational Inspection and Testing. 6-4.1* Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly. Exception: If the generator set is used for standby power or for peak load shaving, such use shall be recorded and shall be permitted to be substituted for scheduled operations and testing of the generator set, provided the appropriate data are recorded. 6-4.2* Generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (a) Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating (b) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer The date and time of day for required testing shall be decided by the owner, based on facility operations. 6-4.2.1 Equivalent loads used for testing shall be</p>	K 144	

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K 144	Continued From page 6 automatically replaced with the emergency loads in case of failure of the primary source. 6-4.2.2 Diesel-powered EPS installations that do not meet the requirements of 6-4.2 shall be exercised monthly with the available EPSS load and exercised annually with supplemental loads at 25 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate rating for 30 minutes, followed by 75 percent of nameplate rating for 60 minutes, for a total of 2 continuous hours.	K 144		