July 18, 2016

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 July 7, 2016, 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. 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 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 August 1, 2016. Failure to submit an acceptable PoC by August 1, 2016, may result in the imposition of civil monetary penalties by August 20, 2016.

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. If a State Form was issued as well, it should also be signed, dated and returned.

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 August 11, 2016, (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 August 11, 2016. A change in the seriousness of the deficiencies on August 11, 2016, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by August 11, 2016, includes the following:
Denial of payment for new admissions effective **October 7, 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 **January 7, 2017**, 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 **July 7, 2016**, 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:

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 **August 1, 2016**. If your request for informal dispute resolution is received after **August 1, 2016**, 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, option 3.

Sincerely,

[Signature]
Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosures
**ENTIRE CONTENTS OF REDACTED DOCUMENT**
K 029  Continued From page 1

Failure to provide doors to hazardous areas which self-close could allow by products of fire to enter the corridor, affecting egress and potentially increasing the spread of fire through the compartment. This deficient practice affected 23 residents, staff and visitors of the 500 wing on the date of the survey. The facility is licensed for 127 SNF/NF beds and had a census of 90 on the day of the survey.

Findings include:

During the facility tour conducted on July 6, 2016 from approximately 10:00 AM to 3:30 PM, observation and operational testing of the door to the soiled linen closet in the 500 wing revealed it would not self-close. When asked, the Environmental Services Director said he was not aware this door was not self-closing.

Actual NFPA standard:

NFPA 101
3.3.13.2 Area, Hazardous.
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.

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 doors entering hazardous areas would self-close has the potential to affect all residents, staff and visitors.

**Facility System**

The door to the soiled linen closet in the 500 wing was unable to close due to the way the barrels were positioned in the soiled linen closet. The barrels were repositioned and the door was able to self-close.

In-servicing was completed for staff in the 500 wing to ensure soiled linen barrels are properly positioned to allow the door to self-close.

The Director of Environmental Services has inspected all soiled linen closets to ensure the doors self-close. Any issues found were corrected.

Weekly inspections x4, bi-weekly inspections x2, and monthly inspections x4 will be completed by the Director of Environmental Services to ensure soiled linen closet doors self-close.

**Quality Assurance and Monitoring**
K 029
Continued From page 2

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:

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.

Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.

K 052

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
August 11, 2016

K 052
Resident Specific

The failure to ensure that fire alarm initiating devices were maintained and not impeded to their operation had the potential to affect all residents, staff and visitors on the date of survey.

Other Residents

The failure to ensure that fire alarm initiating devices were maintained and not impeded to their operation has the potential to affect all residents, staff and visitors.
Facility System

The plastic was removed from the heat detection device in the kitchen. A complete audit of all heat detection devices was completed by the Director of Environmental Services to ensure they are in proper operating condition and are not covered.

Weekly inspections x4, bi-weekly inspections x2, and monthly inspections x4 will be completed by the Director of Environmental Services to ensure all heat detection devices are in proper operating condition. Any issues found will be corrected.

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

August 11, 2016
<table>
<thead>
<tr>
<th>ID PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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<tr>
<td>K 052</td>
<td></td>
<td>Continued From page 4 corrected at the conclusion of system inspection, testing, or maintenance, the system owner or the owner's designated representative shall be informed of the impairment in writing within 24 hours. 7-4 Maintenance. 7-4.1 Fire alarm system equipment shall be maintained in accordance with the manufacturer's instructions. The frequency of maintenance shall depend on the type of equipment and the local ambient conditions.</td>
<td>K 052</td>
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<tr>
<td>K 064</td>
<td>SS=F</td>
<td>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that portable fire extinguishers were installed in accordance with NFPA 10. Failure to ensure portable fire extinguishers were installed at correct heights could result in extinguisher damage or injury during a fire. This deficient practice affected 38 residents, staff and visitors on the date of the survey. The facility is licensed for 127 SNF/NF beds and had a census of 90 on the day of the survey. Findings include: During the facility tour conducted on July 6, 2016 from approximately 10:00 AM to 3:30 PM, observation of portable fire extinguishers installed in the facility revealed the following fire extinguishers were installed at a height of 64-1/2 inches when measured from the floor to the top of the extinguisher:</td>
<td>8/11/16</td>
<td>K 064</td>
<td>Resident Specific The failure to ensure that portable fire extinguishers were installed in accordance with NFPA 10 had the potential to affect 38 residents, staff and visitors on the date of survey. Other Residents The failure to ensure that portable fire extinguishers were installed in accordance with NFPA 10 has the potential to affect all residents, staff and visitors. Facility System The fire extinguishers outside Room 214, Room 403, the Rehab/Beauty Salon, and the chapel have been adjusted and are less than 5 feet above the floor. An inspection of all fire extinguishers has been completed by the Director of Environmental Services to ensure they are at the proper height. Any extinguishers found not to be at the proper height will be adjusted. Weekly inspections x4, bi-weekly</td>
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K064
Continued From page 5

1) Extinguisher located outside room 214
2) Extinguisher located outside room 403
3) Extinguisher located outside of rehab/beauty salon
4) Extinguisher located outside chapel

When asked, the Environmental Services Director stated he was not aware these extinguishers were not installed at the proper height.

Actual NFPA standard:

NFPA 10 1-6 General Requirements.
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).

K067

NFPA 101 LIFE SAFETY CODE STANDARD

Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2

This Standard is not met as evidenced by:
Based on record review and interview, the facility failed to ensure that fire dampers were maintained in accordance with NFPA 90A. Failure

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

August 11, 2016

K067

Resident Specific

The failure to ensure that fire dampers were maintained in accordance with NFPA 90A had the potential to affect 10 residents, staff and visitors in the Eagle Unit and also the potential to affect all interconnected ducting of adjacent smoke compartments on the date of
K 067 Continued From page 6

K 067

to ensure fire dampers are functional could result in allowing fires to communicate through heating and ventilation ducting and grow beyond incipient stages. This deficient practice affected 10 residents, staff and visitors in the Eagle unit with the potential to affect all interconnected ducting of adjacent smoke compartments on the date of the survey. The facility is licensed for 127 SNF/NF beds and had a census of 90 on the day of the survey.

Findings include:

During review of the facility fire damper inspection documentation on July 6, 2016 from approximately 8:30 AM to 10:00 AM, records indicated that five (5) fire dampers in the Eagle unit failed during a functional testing conducted on April 13, 2016. When asked, the Environmental Services Director stated the HVAC (Heating Ventilation and Air Conditioning) vendor had made him aware of the failed dampers.

Actual NFPA standard:

NFPA 90A
3.4.7 Maintenance.
At least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify that they fully close; the latch, if provided, shall be checked; and moving parts shall be lubricated as necessary.

K 147

NFPA 101 LIFE SAFETY CODE STANDARD

SS=F

Electrical wiring and equipment shall be in accordance with National Electrical Code, 9-1.2 (NFPA 99) 18.9.1, 19.9.1
This Standard is not met as evidenced by:
Based on observation and interview, the facility failed to ensure safe electrical installations in

K 147

survey.

Other Residents

The failure to ensure that fire dampers are maintained in accordance with NFPA 90A has the potential to affect all residents, staff and visitors.

Facility System

The five fire dampers that failed on the Eagle Unit have been replaced. The failed fire dampers were in the closed position thus prohibiting smoke to transfer to other smoke compartments. Fire dampers will continue to be inspected by the HVAC company as required. Any fire dampers found not to be working will be repaired or replaced by the HVAC company.

Facility fire damper inspection reports will be reviewed by the Director of Environmental Services to ensure any failed fire dampers are repaired or replaced.

Quality Assurance and Monitoring

The Director of Environmental Services will report any findings to the Quality Assurance and
K 147 Continued From page 7

accordance with NFPA 70. Failure to provide safe and secure electrical installations could result in fires by arcing or electrocution. This deficient practice affected 38 residents, staff and visitors on the date of the survey. The facility is licensed for 127 SNF/NF beds and had a census of 90 on the day of the survey.

Findings include:

1) The mechanical/boiler room off the main kitchen revealed an open electrical box in the ceiling with exposed wiring.

2) Observation of the soiled room at the 200 wing revealed an open four inch by four inch square electrical junction box.

3) Observation of the ceiling of the Activities closet of the 400 wing revealed an open four inch by four inch electrical junction box.

When asked about the open electrical, the Environmental Services Director stated he was not aware of the open boxes.

Actual NFPA standard:

NFPA 70
110.12 Mechanical Execution of Work.
Electrical equipment shall be installed in a neat and workmanlike manner.
(A) Unused Openings. Unused cable or raceway openings in boxes, raceways, auxiliary gutters, cabinets, cutout boxes, meter socket enclosures,

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<td>K 147</td>
<td>Performance Improvement (QAPI) meeting for further monitoring and plan modification if compliance is not met.</td>
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</table>

**Date of compliance**

August 11, 2016

**K 147**

**Resident Specific**

The failure to ensure safe electrical installations in accordance with NFPA 70 had the potential to affect 38 residents, staff and visitors on the date of survey.

**Other Residents**

The failure to ensure safe electrical installations in accordance with NFPA 70 has the potential to affect all residents, staff and visitors.

**Facility System**

The facility's electrician properly covered the electrical box and junction boxes identified under #1, 2, and 3.

An inspection of all electrical junction boxes was completed by
**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**CENTERS FOR MEDICARE & MEDICAID SERVICES**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:**

135085

**(X2) MULTIPLE CONSTRUCTION**

A. BUILDING 02 - ENTIRE BLDG

**(X3) DATE SURVEY COMPLETED:**

07/07/2016

**NAME OF PROVIDER OR SUPPLIER:**

GOOD SAMARITAN SOCIETY - BOISE VILLAGE

**STREET ADDRESS, CITY, STATE, ZIP CODE:**

3115 SYCAMORE DRIVE
BOISE, ID 83703

**SUMMARY STATEMENT OF DEFICIENCIES**

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<td>K 147</td>
<td>Continued From page 8 equipment cases, or housings shall be effectively closed to afford protection substantially equivalent to the wall of the equipment. Where metallic plugs or plates are used with nonmetallic enclosures, they shall be recessed at least 6 mm (¼ in.) from the outer surface of the enclosure. (B) Subsurface Enclosures. Conductors shall be racked to provide ready and safe access in underground and subsurface enclosures into which persons enter for installation and maintenance. (C) Integrity of Electrical Equipment and Connections. Internal parts of electrical equipment, including busbars, wiring terminals, insulators, and other surfaces, shall not be damaged or contaminated by foreign materials such as paint, plaster, cleaners, abrasives, or corrosive residues. There shall be no damaged parts that may adversely affect safe operation or mechanical strength of the equipment such as parts that are broken; bent; cut; or deteriorated by corrosion, chemical action, or overheating.</td>
<td>the facility's electrician and the Director of Environmental Services to ensure no boxes were open or exposed. Any issues found were corrected. Weekly inspections x4, bi-weekly inspections x2, and monthly inspections x4 will be completed by the Director of Environmental Services to ensure safe electrical installations in accordance with NFPA 70.</td>
<td>07/07/2016</td>
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**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**

August 11, 2016