November 25, 2016

Kelly Preskorn, Administrator
Good Samaritan Society - Idaho Falls Village
840 East Elva Street
Idaho Falls, ID 83401-2899

Provider #: 135092

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Ms. Preskorn:

On November 16, 2016, a Facility Fire Safety and Construction survey was conducted at Good Samaritan Society - Idaho Falls 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 (XS) 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 **December 8, 2016.** Failure to submit an acceptable PoC by **December 8, 2016,** may result in the imposition of civil monetary penalties by **December 28, 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 **December 21, 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 **December 21, 2016.** A change in the seriousness of the deficiencies on **December 21, 2016,** may result in a change in the remedy.
The remedy, which will be recommended if substantial compliance has not been achieved by December 21, 2016, includes the following:

Denial of payment for new admissions effective February 16, 2017. 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 May 16, 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 Nate Elkins, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, option 3; 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 November 16, 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 **December 8, 2016**. If your request for informal dispute resolution is received after **December 8, 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,

Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosures
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

**IDaho Falls Village**

ENTIRE STRUCTURE

A. Building 92 - Entire Structure

B. Wing

NAME OF PROVIDER OR SUPPLIER

Good Samaritan Society - Idaho Falls Village

STREET ADDRESS, CITY, STATE, ZIP CODE

640 East Elva Street
Idaho Falls, ID 83401

FORM CMS-2567(02-99) Previous AND STATEMENT

**K 000** INITIAL COMMENTS

The facility is a single story, Type V (111) sprinklered building with a partial basement. It has a composite pitched roof and multiple exits to grade. Original construction was June 1984 with an addition in 1985 and a major renovation in 1995. A new fire alarm/smoke detection system was installed in November 2009. Currently the facility is licensed for 113 beds.

The following deficiencies were cited during the annual fire/life safety survey conducted on November 16, 2015. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.

The Survey was conducted by:

Linda Chaney
Health Facility Surveyor
Facility Fire Safety & Construction

NFPA 101 Building Construction Type and Height

Building Construction Type and Height
2012 EXISTING
Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5

Construction Type
1 I (442), l (332), 11 (222) Any number of stories non-sprinklered and sprinklered
2 II (111) One story

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

**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.

1. All penetrations that were found in the mechanical room and sprinkler riser room have been sealed to prevent the passing of fire, smoke, and dangerous gases between compartments. This was completed 11/30/16.

2. All residents have the potential to be affected by the practice.

3. Inspection of the mechanical rooms and sprinkler riser rooms to be free of unsealed penetrations has been added to the facility.
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

<table>
<thead>
<tr>
<th>Deficiency</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>K 161</td>
<td>Continued From page 1 non-sprinklered Maximum 3 stories sprinklered</td>
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<tr>
<td>3</td>
<td>II (000) Not allowed non-sprinklered</td>
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<tr>
<td>4</td>
<td>III (211) Maximum 2 stories sprinklered</td>
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<td>5</td>
<td>IV (2HH)</td>
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<tr>
<td>6</td>
<td>V (111)</td>
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<tr>
<td>7</td>
<td>III (200) Not allowed non-sprinklered</td>
</tr>
<tr>
<td>8</td>
<td>V (000) Maximum 1 story sprinklered</td>
</tr>
</tbody>
</table>

**Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5)**

**Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.**

This STANDARD is not met as evidenced by:

Based on observation and interview, the facility failed to ensure that the fire and smoke resistant properties of the structure were maintained. Failure to seal penetrations in rated construction assemblies could allow fire, smoke and dangerous gases to pass between compartments during a fire. This deficient practice affected staff and visitors of the Mechanical room abutting the Maintenance office on the date of the survey. The facility is licensed for 113 SNF/NF beds and had a census of 41 on the day of the survey.

**Findings include:**

- TEL's program as a monthly task to be completed by the Environmental Services Director or designee.
- Compliance will be monitored by performing audits on both mechanical and sprinkler riser rooms to be free of unsealed penetrations. Audits will be completed monthly x3 and quarterly x2 by the Environmental Services Director or designee. Audit results will be forwarded to the Quality committee for additional monitoring and/or modification.
- Compliance will be met on or before 12/2/16.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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<tr>
<th>ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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<tr>
<td>K 161</td>
<td>During the facility tour conducted on November 16, 2016 from approximately 9:00 AM to 12:00 PM, observation of the wall separating the Mechanical room to the crawlspace and the wall separating the Sprinkler Riser room to the crawlspace, revealed the following penetrations: Two (2) open six inch by eight inch holes through the wall in the Mechanical room exposing the crawlspace beyond. One (1) open eight inch by eight inch hole through the wall in the Mechanical room exposing the crawlspace beyond. Observation of ducting passing through the wall in the riser room into the crawlspace revealed an approximately 1-1/2&quot; unsealed gap around the duct which exposed the space beyond. One (1) open six inch by eight inch hole in the wall separating the riser room to the crawlspace exposing the space beyond. When asked about the unsealed penetrations, the Maintenance Supervisor stated he was not aware of these holes prior to the survey. Actual NFPA standard: 19.1.6 Minimum Construction Requirements. 19.1.6.1 Health care occupancies shall be limited to the building construction types specified in Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7. (See 8.2.1.) 8.2 Construction and Compartmentation. 8.2.1 Construction. 8.2.1.1 Buildings or structures occupied or used in accordance with the individual occupancy chapters, Chapters 11 through 43, shall meet the</td>
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**NAME OF PROVIDER OR SUPPLIER**

GOOD SAMARITAN SOCIETY - IDAHO FALLS VILLAGE

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

840 EAST ELVA STREET
IDAHO FALLS, ID 83401

**PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:**

135092

**DATE SURVEY COMPLETED**

11/16/2016

**MULTIPLE CONSTRUCTION**

A. BUILDING 02 - ENTIRE STRUCTURE

B. WING

**DATE SURVEY COMPLETED**

11/16/2016
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER: GOOD SAMARITAN SOCIETY· IDAHO FALLS VILLAGE

STREET ADDRESS, CITY, STATE, ZIP CODE: 840 EAST ELVA STREET, IDAHO FALLS, ID 83401

A. BUILDING 02 - ENTIRE STRUCTURE

ID PREFIX TAG: 135092

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

K 161 Continued From page 3
minimum construction requirements of those chapters.

K 211 NFPA 101 Means of Egress - General

Means of Egress - General
Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11.

18.2.1, 19.2.1, 7.1.10.1

This STANDARD is not met as evidenced by:

Based on observation and operational testing, the facility failed to ensure that means of egress were maintained free of obstructions to full instant use in accordance with NFPA 101. Failure to maintain exit doors which do not require excessive force to open could hinder escape during an emergency. This deficient practice affected staff and visitors in the Mechanical/Maintenance rooms and the Helping Hands section on the date of the survey. The facility is licensed for 113 SNF/NF beds and had a census of 41 on the day of the survey.

Findings include:

During the facility tour conducted on November 16, 2016 from approximately 9:00 AM to 12:00 PM, observation and operational testing with the Maintenance Supervisor of the following exit doors revealed they required excessive force to open from the egress side, hindering their use as an exit:

Exit door from the Maintenance Office to the exterior required excessive force to open from the exterior.

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

1. Exit doors located at the maintenance office, electrical room and helping hands have been adjusted to open without excessive force from the egress side. This was completed on 11/28/16.

2. All residents have the potential to be affected by the practice.

3. Inspection of all exit doors to be in good working order and open without excessive force from the egress side has been added to the facility TEL's program as a monthly task to be completed by the Environmental Services Director or designee.

4. Compliance will be monitored by performing audits on all exit doors to open without the use of force from the egress side. Audits will be completed weekly x4, monthly x2 and quarterly x2 by the Environmental Services Director or designee. Audit results will be forwarded to the Quality committee for additional monitoring and/or modification.

5. Compliance will be met on or before 12/2/16.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:
135092

NAME OF PROVIDER OR SUPPLIER
GOOD SAMARITAN SOCIETY - IDAHO FALLS VILLAGE

STREET ADDRESS, CITY, STATE, ZIP CODE
840 EAST ELVA STREET
IDAHO FALLS, ID 83401

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)

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<td>K 211</td>
<td>Continued From page 4 egress side. Exit door leading from the Electrical room to the exterior required excessive force to open from the egress side. Helping Hands exit door to the exterior required excessive force to open from the egress side. Further observation revealed all doors were signed as exits to the exterior of the building. Actual NFPA standard: NFPA 101 7.2.1.4.5 Door Leaf Operating Forces. 7.2.1.4.5.1 The forces required to fully open any door leaf manually in a means of egress shall not exceed 15 lbf (67 N) to release the latch, 30 lbf (133 N) to set the leaf in motion, and 15 lbf (67 N) to open the leaf to the minimum required width, unless otherwise specified as follows: (1) The opening forces for interior side-hinged or pivoted-swinging door leaves without closer's shall not exceed 5 lbf (22 N). (2) The opening forces for existing door leaves in existing buildings shall not exceed 50 lbf (222 N) applied to the latch stile. (3) The opening forces for horizontal-sliding door leaves in detention and correctional occupancies shall be as provided in Chapters 22 and 23. (4) The opening forces for power-operated door leaves shall be as provided in 7.2.1.9.</td>
<td>K 211</td>
<td>12/2/16</td>
</tr>
<tr>
<td>K 355 SS=F</td>
<td>Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 101 Portable Fire Extinguishers 1. All fire extinguishers found to be above 5 feet (60 inches) from the finished floor to the top of the extinguisher have been lowered to meet the 5 foot</td>
<td>K 355</td>
<td>12/2/16</td>
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</table>
K 355 Continued From page 5

NFPA 10, Standard for Portable Fire Extinguishers.
18.3.5.12, 19.3.5.12, NFPA 10
This STANDARD is not met as evidenced by:
Based on observation the facility failed to ensure fire extinguishers were installed in accordance with NFPA 10. Failure to install fire extinguishers at the correct height could hinder access during a fire. This deficient practice affected 41 residents, staff and visitors on the date of the survey. The facility is licensed for 113 SNF/NF beds and had a census of 41 on the day of the survey.

Findings include:

During the facility tour conducted on November 16, 2016 from approximately 9:00 AM to 12:00 PM, observation of the installed portable fire extinguishers revealed the following extinguishers were installed over the maximum height of 6 inches to the top of the extinguisher when measured from the finished floor:

Outside room #107: the extinguisher top was 66 inches from the floor
Dining room: the extinguisher top was 63-1/2 inches from the floor
Outside room #131: the extinguisher top was 64-1/2 inches from the floor
Kitchen: the extinguisher top was 63 inches from the floor
Lobby: the extinguisher top was 68 inches from the floor
Hall outside of Housekeeping: the extinguisher top was 68 inches from the floor.
Therapy: the extinguisher top was 68 inches from the floor.
Hall by room 316: the extinguisher top was 66 inches from the floor.

K 355 regulation. This was completed on 11/30/16.

2. All residents have the potential to be affected by the practice.

3. Inspection of all fire extinguishers to be at a height no greater than 5 feet from the floor to the top of the extinguisher has been added to the facility TEL's program as a monthly task to be completed by the Environmental Services Director or designee.

4. Compliance will be monitored by performing audits of fire extinguishers not to be greater than 5 feet from the floor to the top of the extinguisher. Audits will be completed monthly x3 and quarterly x2 by the Environmental Services Director or designee. Audit results will be forwarded to the Quality committee for additional monitoring and/or modification.

5. Compliance will be met on or before 12/2/16.
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<tr>
<td>K355</td>
<td>Continued From page 6</td>
<td>Maintenance office: the extinguisher top was 64-1/2 inches from the floor. Due to the extent and number of locations observed, the condition was deemed widespread and further documentation was not required.</td>
<td>K355</td>
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<td>6.1.3.8 Installation Height. 6.1.3.8.1 Fire extinguishers having a gross weight not exceeding 40 l (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.</td>
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