July 3, 2018

Trevor Guthmiller, 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. Guthmiller:

On June 20, 2018, 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. 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 **July 16, 2018.** Failure to submit an acceptable PoC by **July 16, 2018,** may result in the imposition of civil monetary penalties by **August 5, 2018.**

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 may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **July 25, 2018,** (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 **July 25, 2018.** A change in the seriousness of the deficiencies on **July 25, 2018,** may result in a change in the remedy.
The remedy, which will be recommended if substantial compliance has not been achieved by July 25, 2018, includes the following:

Denial of payment for new admissions effective September 20, 2018.
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 December 20, 2018, 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 June 20, 2018, 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 July 16, 2018. If your request for informal dispute resolution is received after July 16, 2018, 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
E 000 Initial Comments

The facility is a single-story, type V (111) construction built in 1975. The building is fully sprinklered with a complete fire alarm/smoke detection system. There is an assisted living wing with adjacent independent living wing with a two (2) hour fire wall separation between the assisted living and independent living. The facility is currently licensed for 50 beds, and had a census of 32 on the date of the survey.

The following deficiency was cited during the Emergency Preparedness Survey conducted on June 20, 2018. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73.

The Survey was conducted by:

Linda Chaney
Health Facility Surveyor
Facility Fire Safety & Construction

E 041 Hospital CAH and LTC Emergency Power
SS=F CFR(s): 483.73(e)

(e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section.

§483.73(e), §485.625(e)

(e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section.

Generator testing and documentation monthly/weekly was completed by the Environmental Services Director. Weekly inspections were completed on 6/25/18, 7/2/18, 7/9/18. Monthly inspection and documentation was completed on 6/29/18. The annual generator diesel fuel

RECEIVED
JUL 13 2018
FACILITY STANDARDS

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided 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.
Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated.

Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code.

Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates.

Testing sample was obtained for testing on 7/12/18 by a contractor. All residents, staff, and visitors have the potential to be affected by this practice.

Generator inspections are on the facility TELs program as a weekly and monthly task to be completed by the Environmental Services Director or Designee. The diesel fuel testing is also on the facility TELs program as an annual task for the Environmental Services Director to complete.

Compliance will be monitored by performing audits of the generator inspections to be completed. 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 QAPI committee for additional monitoring or modification.

Compliance will be met on or before July 25, 2018.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
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<tr>
<th>ID</th>
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<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
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<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tr>
<td>E 041</td>
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Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: [http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html](http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html).

If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes.

   (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011.
   (iii) TIA 12-3 to NFPA 99, issued August 9, 2012.
   (iv) TIA 12-4 to NFPA 99, issued March 7, 2013.
   (v) TIA 12-5 to NFPA 99, issued August 1, 2013.
   (vi) TIA 12-6 to NFPA 99, issued March 3, 2014.
   (viii) TIA 12-1 to NFPA 101, issued August 11, 2011.
   (x) TIA 12-2 to NFPA 101, issued October 30, 2012.
   (x) TIA 12-3 to NFPA 101, issued October 22, 2013.
   (x) TIA 12-4 to NFPA 101, issued October 22, 2013.
   (xii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAS to chapter 7, issued August 6, 2009. This REQUIREMENT is not met as evidenced by:

Based on record review and interview, the facility...
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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<tr>
<th>(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
<th>(X3) DATE SURVEY COMPLETED</th>
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<tr>
<td>135058</td>
<td>A. BUILDING __________________</td>
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<td>B. WING ____________________</td>
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NAME OF PROVIDER OR SUPPLIER

GOOD SAMARITAN SOCIETY - SILVER WOOD VILLAGE

STREET ADDRESS, CITY, STATE, ZIP CODE

405 WEST SEVENTH STREET

SILVERTON, ID 83867

E 041

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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
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E 041 Continued From page 3

failed to ensure the generator for the EES (Essential Electrical System) was maintained in accordance with NFPA 110. Failure to inspect and test EES generators could result in a lack of system reliability during a power loss. This deficient practice affected 32 residents, staff and visitors on the date of the survey.

Findings Include:

Review of the facility generator inspection and testing records on June 20, 2018, from approximately 11:30 AM to 3:00 PM, revealed the facility failed to provide the following weekly generator inspection logs:

1.) December 31, 2017 - January 6, 2018
2.) January 7 - 13, 14 - 20, 21 - 27, 2018
3.) All of February 2018
4.) March 4 - 10, 18 -24, and 25 - 31, 2018
5.) April 29 - May 5, 2018
6.) May 20 - 26, 27 - June 2, 2018
7.) June 3 - 9, 2018

When asked, the Maintenance Director stated the facility strongly believed the inspections had been completed but were not documented properly.

Reference:

42 CFR 483.73 (e) (2)
The facility is a single-story, type V (111) construction built in 1975. The building is fully sprinklered with a complete fire alarm/smoke detection system. There is an assisted living wing with adjacent independent living wing with a two (2) hour fire wall separation between the assisted living and independent living. The facility is currently licensed for 50 beds, and had a census of 32 on the date of the survey.

The following deficiencies were cited during the annual fire/life safety survey conducted on June 20, 2018. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Chapter 19, Existing Healthcare Occupancies, in accordance with 42 CFR 483.70, 42 CFR 483.80 and 42 CFR 483.65.

The survey was conducted by:

Linda Chaney
Health Facility Surveyor
Facility Fire Safety and Construction

K 132  Multiple Occupancies - Contiguous Non-Health Care Occupancies

Multiple Occupancies - Contiguous Non-Health Care Occupancies
Non-health care occupancies that are located immediately next to a Health Care Occupancy, but are primarily intended to provide outpatient services are permitted to be classified as Business or Ambulatory Health Care Occupancies, provided the facilities are separated by construction having not less than 2-hour fire resistance-rated construction, and are not intended to provide services simultaneously for
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:**

**NAME OF PROVIDER OR SUPPLIER:**

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

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

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**K 132**

Continued From page 1

four or more inpatients. Outpatient surgical departments must be classified as Ambulatory Health Care Occupancy regardless of the number of patients served.

18.1.3.4.1, 19.1.3.4.1

This REQUIREMENT is not met as evidenced by:

Based on observation, operational testing, and interview the facility failed to maintain a two-hour separation between occupancies. Failure to maintain a two-hour separation between the skilled nursing facility and the residential assisted living facility could allow a fire event to spread quickly between the two occupancies, inhibiting defend in place. This deficient practice has the potential to affect 32 residents, staff, and visitors on the date of survey.

Findings include:

During the facility tour on June 20, 2018, from approximately 3:00 PM to 5:30 PM, observation of the double doors to the residential assisted living facility, revealed the doors were rated for 30 minutes, providing a 1-hour separation between the two occupancies, not the 2-hours required. When asked, the Administrator and Maintenance Director stated the facility was unaware the doors did not meet the requirements for separation of the two occupancies.

Actual NFPA Standards:

19.1.3.4.1* Ambulatory care facilities, medical clinics, and similar facilities that are contiguous to health care occupancies, but are primarily intended to provide outpatient services, shall be permitted to be classified as business occupancies or ambulatory health care facilities,

We are working diligently to acquire a contractor to provide and install 90 minute rated doors to provide the two-hour separation between occupancies. The location of our facility has made this challenging. We are currently waiting for several contractors to arrive at our facility to quote this task.

All residents, staff, and visitors have the potential to be affected by this practice.

Inspection of the 90 minute rated doors to be in good working order to maintain the required 2-hour separation between the skilled nursing facility and the residential assisted living has been added to the facilities TELs program as a monthly task to be completed by the Environmental Services Director or designee.

Compliance will be monitored by performing audits of the 90 minute rated door to be in place between the two occupancies and in good working order. Audits will be completed monthly X3 and quarterly X2 by the Environmental Services Director or designee. Audit results will be forwarded to the QAPI committee for additional monitoring or modification.
K 132 Continued From page 2

provided that the facilities are separated from the health care occupancy by not less than 2-hour fire resistance-rated construction, and the facility is not intended to provide services simultaneously for four or more inpatients who are litterborne.

Definitions

3.3.140.2 Nursing Home. A building or portion of a building used on a 24-hour basis for the housing and nursing care of four or more persons who, because of mental or physical incapacity, might be unable to provide for their own needs and safety without the assistance of another person.

3.3.88.2* Limited Care Facility. A building or portion of a building used on a 24-hour basis for the housing of four or more persons who are incapable of self-preservation because of age; physical limitations due to accident or illness; or limitations such as mental retardation/developmental disability, mental illness, or chemical dependency.

K 291 Emergency Lighting

Emergency light testing and documentation has been completed.

Emergency light testing and documentation has been completed. 30 second test was completed and documented on 6/22/18 by the Environmental Services Director. 90 minute test was completed and documented on 7/10/18.

All residents, staff, and visitors have
Findings include:

During record review on June 20, 2018, from approximately 9:00 AM to 3:00 PM, revealed no documentation for the 30 second monthly and 90-minute annual testing of emergency lighting. When asked, the Maintenance Supervisor stated the facility was unaware the tests were not completed or documentation maintained.

Actual NFPA reference:

NFPA 101
19.2.9 Emergency Lighting
19.2.9.1 Emergency lighting shall be provided in accordance with Section 7.9.
7.9.3 Periodic Testing of Emergency Lighting Equipment.
7.9.3.1 Required emergency lighting systems shall be tested in accordance with one of the three options offered by 7.9.3.1.1, 7.9.3.1.2, or 7.9.3.1.3.
7.9.3.1.1 Testing of required emergency lighting systems shall be permitted to be conducted as follows:
(1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, except as otherwise permitted by 7.9.3.1.1(2).
(2)*The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having jurisdiction.
(3) Functional testing shall be conducted annually for a minimum of 1-1/2 hours if the emergency lighting system is battery powered.
(4) The emergency lighting equipment shall be fully operational for the duration of the tests.

Completion of emergency light testing and documentation that includes 30 seconds monthly and 90 minutes annually is on the facility TELs program as a monthly task to be completed by the Environmental Services Director or designee.

Compliance will be monitored by performing audits on the emergency light testing documentation. Audits will be completed monthly X3 and quarterly X2 by the Environmental Services Director or designee. Audit results will be forwarded to the QAPI committee for additional monitoring or modification.

Compliance will be met on or before July 25, 2018.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**K 291 Continued From page 4**

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<tr>
<td>K 291</td>
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<td>Required by 7.9.3.1.1(1) and (3). (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. 7.9.3.1.2 Testing of required emergency lighting systems shall be permitted to be conducted as follows: (1) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall be provided. (2) Not less than once every 30 days, self-testing/self-diagnostic battery-operated emergency lighting equipment shall automatically perform a test with a duration of a minimum of 30 seconds and a diagnostic routine. (3) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall indicate failures by a status indicator. (4) A visual inspection shall be performed at intervals not exceeding 30 days. (5) Functional testing shall be conducted annually for a minimum of 1-1/2 hours. (6) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall be fully operational for the duration of the 1-1/2-hour test. (7) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. 7.8.3.1.3 Testing of required emergency lighting systems shall be permitted to be conducted as follows: (1) Computer-based, self-testing/self-diagnostic battery-operated emergency lighting equipment shall be provided. (2) Not less than once every 30 days, emergency lighting equipment shall automatically perform a test with a duration of a minimum of 30 seconds and a diagnostic routine.</td>
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**PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:**

| 135058 |

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

| 405 WEST SEVENTH STREET | SILVERTON, ID 83867 |

**NAME OF PROVIDER OR SUPPLIER:**

| GOOD SAMARITAN SOCIETY - SILVER WOOD VILLAGE |

**ID PREFIX TAG:**

| STREET ADDRESS, CITY, STATE, ZIP CODE |

| 405 WEST SEVENTH STREET | SILVERTON, ID 83867 |

**DATE SURVEY COMPLETED:**

| 06/20/2018 |

**FORM CMS-2567(02-99) Previous Versions Obsolete Event ID:**

| FORM APPROVED OMB NO. 0938-0391 |

| PRINTED: 07/02/2018 |

**MULTIPLE CONSTRUCTION**

| A. BUILDING 02 - ENTIRE BUILDING |

| BUILDING 02 • ENTIRE BUILDING |

**COMPLETION DATE:**

| 06/20/2018 |

**COMPLETION DATE:**

| 06/20/2018 |

**PROVIDER'S PLAN OF CORRECTION**

| EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY | (X5) COMPLETION DATE |

| K 291 | 06/20/2018 |
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135058

NAME OF PROVIDER OR SUPPLIER
GOOD SAMARITAN SOCIETY - SILVER WOOD VILLAGE

STREET ADDRESS, CITY, STATE, ZIP CODE
405 WEST SEVENTH STREET
SILVERTON, ID 83867

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<tr>
<td>K281</td>
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<td>(3) The emergency lighting equipment shall automatically perform annually a test for a minimum of 1-1/2 hours. (4) The emergency lighting equipment shall be fully operational for the duration of the tests required by 7.9.3.1.3(2) and (3). (5) The computer-based system shall be capable of providing a report of the history of tests and failures at all times.</td>
<td>K291</td>
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<td>The annual fire alarm system testing was completed on 6/29/18 by a contractor.</td>
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<td>K345</td>
<td>SS=F</td>
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<td>Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101</td>
<td>K345</td>
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<td>All residents, staff, and visitors have the potential to be affected by this practice.</td>
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Fire Alarm System - Testing and Maintenance
A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72
This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to ensure fire alarm systems were tested and maintained. Failure to maintain fire alarm systems could result in a lack of system performance during a fire event. This deficient practice affected 32 residents, staff and visitors on the date of the survey.

Findings include:
During review of the facility inspection records on June 20, 2018, from approximately 9:00 AM to 3:00 PM, The only documentation available for an annual inspection of the fire alarm system was dated April 19, 2017. When asked, the...
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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<tr>
<td>135058</td>
<td>A. BUILDING 02 - ENTIRE BUILDING</td>
<td>06/20/2018</td>
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#### NAME OF PROVIDER OR SUPPLIER

**GOOD SAMARITAN SOCIETY - SILVER WOOD VILLAGE**

#### STREET ADDRESS, CITY, STATE, ZIP CODE

405 WEST SEVENTH STREET

SILVERTON, ID 83867

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<td>K 345</td>
<td>Maintenance Director stated the facility was not aware the annual inspection was past due.</td>
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<td>Actual NFPA standard:</td>
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<td><strong>NFPA 101</strong></td>
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<td>19.3.4 Detection, Alarm, and Communications Systems.</td>
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<td>19.3.4.1 General. Health care occupancies shall be provided with a fire alarm system in accordance with Section 9.6.</td>
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<td>9.6.1.3 A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm and Signaling Code, unless it is an approved existing installation, which shall be permitted to be continued in use.</td>
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<td><strong>NFPA 72</strong></td>
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<td>14.3 Inspection.</td>
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<td>14.3.1* Unless otherwise permitted by 14.3.2 visual inspections shall be performed in accordance with the schedules in Table 14.3.1 or more often if required by the authority having jurisdiction. (See Table 14.3.1)</td>
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<td>14.4 Testing.</td>
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<td>14.4.5* Testing Frequency. Unless otherwise permitted by other sections of this Code, testing shall be performed in accordance with the schedules in Table 14.4.5, or more often if required by the authority having jurisdiction. (See Table 14.4.5)</td>
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<tr>
<td>K 355</td>
<td>Portable Fire Extinguishers</td>
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| CFR(s): NFPA 101 | Forwarded to the QAPI committee for additional monitoring or modification.                          |                     |

Compliance will be met on or before July 25, 2018.
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<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>PROVIDERS PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>K 355</td>
<td>Continued From page 7</td>
<td></td>
<td>Portable Fire Extinguishers</td>
<td>The portable fire extinguishers monthly inspection and documentation was completed by the Environmental Services Director and is now up to date as of 6/21/18.</td>
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<td>Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers.</td>
<td>All residents, staff, and visitors have the potential to be affected by this practice.</td>
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<tr>
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<td>18.3.5.12, 19.3.5.12, NFPA 10</td>
<td>Monthly inspections of the facility portable fire extinguishers to be completed and documented monthly is located on the facilities TELs program as a monthly task to be completed by the Environmental Services Director or designee.</td>
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<td>This REQUIREMENT is not met as evidenced by:</td>
<td>Compliance will be monitored by performing audits on the completion of the monthly inspections of facility portable fire extinguishers. Audits will be completed monthly X12 by the Environmental Services Director or designee. Audit results will be forwarded to the QAPI committee for additional monitoring or modification.</td>
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<td>Based on observation and interview, the facility failed to ensure portable fire extinguishers were inspected and maintained. Failure to inspect and maintain portable fire extinguishers could result in a lack of performance during a fire event. This deficient practice affected 32 residents, staff and visitors on the date of the survey.</td>
<td>Compliance will be met on or before July 25, 2018.</td>
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<td>Findings include:</td>
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<td>During the facility tour on June 20, 2018, from approximately 3:00 PM to 5:30 PM, observation of the fire extinguishers throughout the facility revealed they were inspected annually in September of 2017, but had only had monthly inspections in January and February of 2018. When asked, the Maintenance Director stated he wasn't sure what to do because the extinguishers were already past due when he was hired, and he didn't feel comfortable falsifying documentation by filling in the tags for the monthly inspections.</td>
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<td>Actual NFPA standard:</td>
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<td>NFPA 10</td>
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<td>7.2.1.2* Fire extinguishers shall be inspected either manually or by means of an electronic monitoring device/system at a minimum of 30-day intervals.</td>
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<td>7.2.4.3 Where at least monthly manual</td>
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</table>
**DEPARTMENT OF HEALTH AND HUMAN SERVICES**
**CENTERS FOR MEDICARE & MEDICAID SERVICES**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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

135058

**NAME OF PROVIDER OR SUPPLIER:**

GOOD SAMARITAN SOCIETY - SILVER WOOD VILLAGE

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

405 WEST SEVENTH STREET
SILVERTON, ID 83867

---

**SUMMARY STATEMENT OF DEFICIENCIES**

**EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION**

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**K 355 Continued From page 8**

Inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded.

**K 712 Fire Drills**

SS=F CFR(s): NFPA 101

Fire Drills

Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.

19.7.1.4 through 19.7.1.7

This REQUIREMENT is not met as evidenced by:

Based on record review and interview, the facility failed to provide documentation of required fire drills, one per shift per quarter. Failure to perform fire drills on each shift quarterly could result in confusion and hinder the safe evacuation of residents during a fire event. This deficient practice affected 32 residents, staff and visitors on the date of the survey.

Findings include:

During record review on June 20, 2018 from approximately 9:00 AM to 3:00 PM, fire drill documentation revealed the facility failed to perform the following fire drills:

1. First shift, first quarter 2018.

**K 355**

A fire drill was conducted on 6/28/18 for the first shift by the Environmental Services Director. A fire drill will be conducted one per shift per quarter to prepare the employees in the event of an actual emergency.

All residents, staff, and visitors have the potential to be affected by this practice.

Monthly fire drills, one per shift per quarter is on the facilities TEL program as a monthly task to be completed by the Environmental Services Director or designee.

Compliance will be monitored by performing audits on the completion of facility fire drills. Audits will be completed monthly X12 by the Environmental Services Director or designee. Audit results will be forwarded to the QAPI committee for additional monitoring or modification.

Compliance will be met on or before July 25, 2018.
### K 712

Continued From page 9

3.) Third shift, third quarter 2017.

When asked, the Maintenance Director stated the facility was unaware of the missing fire drills.

Actual NFPA standard:

19.7.1.6 Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions.

### K 741

Smoking Regulations

Smoking regulations shall be adopted and shall include not less than the following provisions:

1. Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking.

2. In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required.

3. Smoking by patients classified as not responsible shall be prohibited.

4. The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision.

5. Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.

6. Metal containers with self-closing cover

The designated employee smoking area has been adjusted to include ashtrays of noncombustible material and safe design (smoker pole). This was completed on 6/26/18. A metal garbage can with self-closing lid has been ordered. This was done on 7/10/18.

All residents, staff, and visitors have the potential to be affected by this practice.

Designated employee smoking area will be inspected weekly to contain the proper disposal receptacles by the Environmental Services Director or designee. Weekly Inspection of the
### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CUA Identification Number:**

135058

**Name of Provider or Supplier:**

GOOD SAMARITAN SOCIETY - SILVER WOOD VILLAGE

**Street Address, City, State, Zip Code:**

405 WEST SEVENTH STREET

SILVERTON, ID 83867

**ID Prefix Tag:**

K 741

**Summary Statement of Deficiencies**

(Each deficiency must be preceded by full regulatory or LSC identifying information)

1. Devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4

   This REQUIREMENT is not met as evidenced by:

   Based on observation and interview, the facility failed to ensure smoking was conducted in designated areas equipped with proper receptacles. Failure to conduct smoking in areas equipped with proper disposal receptacles could expose residents, staff and visitors to increased risk of fire associated with the practice of smoking. This deficient practice affected staff and visitors utilizing the smoking area.

   Findings include:

   During the facility tour on June 20, 2018, from approximately 3:00 PM to 5:30 PM, observation revealed the designated smoking area for staff lacked ashtrays of noncombustible material and safe design. Two five-gallon buckets were being used as ashtrays, and there was no metal can with a self-closing cover available to dump cigarette butts into. Combustible trash was also observed in the five-gallon buckets and the trash receptacle provided, all with cigarette butts intermixed. When asked, the Maintenance Director stated the facility was not aware of the smoking requirements.

   Actual standard:

   NFPA 101

   19.7.4* Smoking. Smoking regulations shall be adopted and shall

   **Employee smoking area has been added to the facilities TELs program as a weekly task to be completed by the Environmental Services Director or designee.**

   Compliance will be monitored by performing audits of the employee smoking area to contain the proper disposal receptacles. Audits will be completed weekly x4, monthly x2, quarterly x2 by the Environmental Services Director or designee. Audit results will be forwarded to the QAPI committee for additional monitoring or modification.

   Compliance will be met on or before July 25, 2018.
STATEMENT OF DEFIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:

135058

(X2) MULTIPLE CONSTRUCTION
A. BUILDING 02 - ENTIRE BUILDING

B. WING

(X3) DATE SURVEY COMPLETED

06/20/2018

NAME OF PROVIDER OR SUPPLIER

GOOD SAMARITAN SOCIETY - SILVER WOOD VILLAGE

STREET ADDRESS, CITY, STATE, ZIP CODE

405 WEST SEVENTH STREET
SILVERTON, ID 83867

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<tr>
<td>K 741</td>
<td>Continued From page 11</td>
<td>include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or individual enclosed space where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 19.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.</td>
<td>K 741</td>
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<td>K 911</td>
<td>Electrical Systems - Other</td>
<td>CFR(s): NFPA 101</td>
<td>Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility</td>
<td>K 911</td>
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| K 911 | Continued From page 12 | | K 911 failed to ensure the Essential Electrical System (EES) generator was equipped with a remote manual stop switch. Failure to provide a remote stop switch prohibits the protection from the impact of adverse generator conditions. This deficient practice affected 32 residents, staff and visitors on the date of the survey. Findings include:

During the facility tour conducted on June 20, 2018 from approximately 3:00 PM to 5:30 PM, observation revealed the facility did not provide a remote manual stop switch for the EES generator in a remote location. When asked, both the Maintenance Director and the Administrator stated the facility was not equipped with a remote stop switch.

Actual NFPA standard:

NFPA 110

5.6.5.6* All installations shall have a remote manual stop station of a type to prevent inadvertent or unintentional operation located outside the room housing the prime mover, where so installed, or elsewhere on the premises where the prime mover is located outside the building.

5.6.5.6.1 The remote manual stop station shall be labeled.

NFPA 99

6.4.1.1.16.2 Safety indications and shutdowns shall be in accordance with Table 6.4.1.1.16.2. (SEE TABLE)

K 918 Electrical Systems - Essential Electric Syste | K 918 | The generator remote manual stop switch was installed on 7/12/18 by a contractor. The manual stop switch is located in mechanical room #1 away from the generator that is located outside of the facility.

All residents, staff, and visitors have the potential to be affected by this practice.

Education was provided at an all-staff meeting to inform the employees of its location and the purpose of the remote manual stop switch. All-staff was held on 7/10/18.

The generator remote manual stop switch is a permanent correction and will not require any auditing of its existence.

Compliance will be met on or before July 25, 2018.
### Electrical Systems - Essential Electric System Maintenance and Testing

The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.

Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.

6.4.4, 6.5.4, 8.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)

This REQUIREMENT is not met as evidenced by:

Based on record review and interview, the facility

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<th>(X5) COMPLETION DATE</th>
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<tbody>
<tr>
<td>K 918</td>
<td></td>
<td>Continued From page 13</td>
<td>K 918</td>
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<td>Generator testing and documentation monthly/weekly was completed by the Environmental Services Director. Weekly inspections were completed on 6/25/18, 7/2/18, 7/9/18. Monthly inspections and documentation was completed on 6/29/18. The annual generator diesel fuel testing sample was obtained for testing on 7/12/18 by a contractor. All residents, staff, and visitors have the potential to be affected by this practice. Generator inspections are on the facility TELs program as a weekly and monthly task to be completed by the Environmental Services Director or Designee. The diesel fuel testing is also on the facility TELs program as an annual task for the Environmental Services Director to complete.</td>
<td>06/20/2018</td>
</tr>
</tbody>
</table>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:
135058

(X2) MULTIPLE CONSTRUCTION
A. BUILDING 02 - ENTIRE BUILDING
B. WING

(X3) DATE SURVEY COMPLETED
06/20/2018

STREET ADDRESS, CITY, STATE, ZIP CODE
405 WEST SEVENTH STREET
SILVERTON, ID 83867

GOOD SAMARITAN SOCIETY · SILVERWIND VILLAGE

K 918
Continued From page 14
failed to ensure Emergency Power Supply Systems (EPSS) were properly maintained.
Failure to inspect and test generators and stored diesel fuel, could hinder the performance of the equipment during an emergency. This deficient practice affected 32 residents, staff and visitors on the date of the survey.

Findings include:

Review of the facility generator inspection and testing records on June 20, 2018, from approximately 11:30 AM to 3:00 PM, revealed the facility failed to test the diesel fuel quality as part of the annual inspection. The facility also failed to provide the following weekly generator inspection logs:

1.) December 31, 2017 - January 6, 2018
2.) January 7 - 13, 14 - 20, 21 - 27, 2018
3.) All of February 2018
4.) March 4 - 10, 18 - 24, and 25 - 31, 2018
5.) April 29 - May 5, 2018
6.) May 20 - 26, 27 - June 2, 2018
7.) June 3 - 9, 2018

When asked, the Maintenance Director stated the facility strongly believed the inspections had been completed but were not documented properly.

Actual NFPA standard:

NFPA 110
8.3 Maintenance and Operational Testing.
8.3.8 A fuel quality test shall be performed at least annually using tests approved by ASTM standards.
8.4 Operational Inspection and Testing.
8.4.1* EPSSs, including all appurtenant components, shall be inspected weekly and exercised under load at least monthly.

Provider's Plan of Correction (Each corrective action should be cross-referenced to the appropriate deficiency)

K 918
Compliance will be monitored by performing audits of the generator inspections to be completed. 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 QAPI committee for additional monitoring or modification.

Compliance will be met on or before July 25, 2018.
### Summary Statement of Deficiencies

**K918** Continued from page 15

8.4.2* Diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:

1. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer
2. Under operating temperature conditions and at not less than 30 percent of the EPS nameplate kW rating

8.4.2.3 Diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS load and shall be exercised annually with supplemental loads at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours.