IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
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CERTIFIED MAIL: 7012 1010 0002 0836 3905

April 9, 2014

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 **April 3, 2014**, a Facility Fire Safety and Construction survey was conducted at **Good Samaritan Society-- Boise Village** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. Please provide ONLY ONE completion date for each federal and state tag in column (X5) Completion Date to signify when you allege that each tag will be back in compliance. **NOTE**: The alleged compliance date must be after the "Date

Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign both Statement of Deficiencies and Plan of Correction, Form CMS-2567 and State Form, in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **April 22, 2014**. Failure to submit an acceptable PoC by **April 22, 2014**, may result in the imposition of civil monetary penalties by **May 12, 2014**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.
- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567 and the state licensure survey report, State Form.

All references to federal regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **May 8, 2014**, (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 **May 8, 2014**. A change in the seriousness of the deficiencies on **May 8, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **May 8, 2014**, includes the following:

Denial of payment for new admissions effective **July 3, 2014**.
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 **October 3, 2014**, 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 **April 3, 2014**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx

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 **April 22, 2014**. If your request for informal dispute resolution is received after **April 22, 2014**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,

Mark P. Grimes, Supervisor
Facility Fire Safety and Construction

MPG/lj
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING	(X3) DATE SURVEY COMPLETED
	135085		04/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOISE VILLAGE	3115 SYCAMORE DRIVE BOISE, ID 83703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The facility is a single story, type V(111) construction with multiple additions and renovations. The most recent addition was completed in 2002 on the West side. A new complete fire alarm/smoke detection system was installed in 2001. The facility was originally built in 1957 and is fully sprinklered with the oldest portion of the building being demolished in 2007. Currently it is licensed for 127 SNF/NF beds. The following deficiencies were cited during the annual fire/life safety survey conducted on April 3, 2014. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70. The Survey was conducted by: Mark Grimes, Supervisor Facility Fire Safety & Construction Program IDHW Dan Holbrook, Health Facility Surveyor, IDHW Sam Burbank, Health Facility Surveyor, IDHW	K 000	**General Disclaimer** 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.	
			K 021	5/2/13
K 021 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system;	K 021	***Resident Specific*** The failure to ensure the smoke barrier doors at the corridor entrance to the main dining room would close or latch had the potential to affect the residents, staff, and visitors using the main dining room. ***Other Residents*** The failure to ensure smoke barrier	

RECEIVED
APR 18 2014
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	4/18/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 021	Continued From page 1 b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 This STANDARD is not met as evidenced by: Base upon observation and operational testing facility failed to maintain smoke barrier doors so they would self close and latch. This could potentially affect all residents, staff and visitors using the dining room. The facility is licensed for 127 beds and had a census of 90 on the date of the survey. Findings include: During the facility tour on April 3, 2014 at approximately 1:15 PM, operational testing of the smoke barrier doors at the corridor entrance to the dining room on the east would not close or latch. Secondary testing revealed a rise in the flooring prevented the door from closing completely. Actual NFPA standard: LSC- 2000 19.3.7.6* Doors in smoke barriers shall comply with 8.3.4 and shall be self-closing or automatic-closing in accordance with 19.2.2.2.6. Such doors in smoke barriers shall not be required to swing with egress	K 021	doors close or latch has the potential to affect all residents, staff, and visitors. ***Facility System*** Prior to survey inspection, the transition strip from the carpeted floor to the tiled floor was replaced after tile work was completed on the floor. A taller transition strip was mistakenly placed down after the repair, interrupting the action of the smoke barrier door. The correct transition strip was placed on 4/4/14 and the doors close freely. This smoke barrier door threshold is the only one in the facility that transitions from carpet to tile. Any future work on any smoke barrier door will not be considered complete until the door functionality is tested, witnessed, and documented by the Environmental Services Director. The Environmental Services Director will check all smoke barrier doors weekly x4, bi-weekly x2, and monthly x4 to ensure proper closure and will record the results on a log form. ***Quality Assurance and Monitoring*** The Environmental Services	

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K 021	Continued From page 2 travel. Positive latching hardware shall not be required. 8.3.4.3* Doors in smoke barriers shall be self-closing or automatic-closing in accordance with 7.2.1.8 and shall comply with the provisions of 7.2.1.	K 021	Director will report any findings to the Quality Improvement Meeting for further monitoring and plan modification if compliance is not met. ***Date of compliance*** May 2, 2014	
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based upon observation the facility failed to maintain adequate continuity of the smoke barrier. Failure to maintain continuity of the smoke barrier has the potential to allow smoke and dangerous gases to pass into adjacent areas. This deficient practice affected 57 residents, all staff and visitors in five of nine smoke compartments. The facility is licensed for 127 beds and had a census of 90 on the date of the survey. Findings include:	K 025	**K 025** ***Resident Specific*** The failure to maintain adequate continuity of the smoke barrier had the potential to affect 57 residents, as well as staff and visitors in five of nine smoke compartments. ***Other Residents*** The failure to maintain adequate continuity of the smoke barrier has the potential to affect all residents, staff and visitors. ***Facility System*** The unsealed penetrations identified by survey will be sealed by 4/25/14. As a second step, a complete audit of all smoke barriers will be completed by 4/25/14. Any other barrier penetrations identified from the second audit will be sealed.	5/2/14

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K 025	Continued From page 3 During the tour of the facility conducted on April 3, 2014 between the hours of 3:45 to 4:50 PM inspection of the smoke barriers above ceiling locations (near room numbers 201/202; 501/502), were observed to have unsealed penetrations. 1. At the smoke barrier wall near rooms 201/202 a penetration was observed approximately 12 inches by 8 inches partially filled with red fire pillows. When light was applied to one side of the penetration light was clearly observed on the opposite side, indicating a passageway for smoke. 2. At the smoke barrier wall near rooms 501/502 a penetration was observed above the ceiling. This penetration was two empty conduits which were unsealed. Actual NFPA standard: LSC - 2000 19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour. Exception No. 1: Where an atrium is used, smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with Exception No. 2 to 8.2.5.6(1). Not less than two separate smoke compartments shall be provided on each floor. Exception No. 2*: Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.3 has been provided for smoke	K 025	All work that requires barrier penetrations will require the Environmental Services Director's approval and sign off and be inspected for compliance. Inspection documentation will be kept in a logbook noting what was installed, purpose, contractor and signature of person performing the work. Weekly inspections x4, Bi-Weekly inspections x2, and Monthly inspections x4 will be done by the Environmental Services Director to ensure all smoke barriers are properly sealed. ***Quality Assurance and Monitoring*** The Environmental Services Director will report any findings to the Quality Improvement Meeting for further monitoring and plan modification if compliance is not met. ***Date of compliance*** May 2, 2014	

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K 025	Continued From page 4 compartments adjacent to the smoke barrier. 8.3.2* Continuity. Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces. Exception: A smoke barrier required for an occupied space below an interstitial space shall not be required to extend through the interstitial space, provided that the construction assembly forming the bottom of the interstitial space provides resistance to the passage of smoke equal to that provided by the smoke barrier.	K 025		
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based upon observation the facility failed to	K 029	**K 029** ***Resident Specific*** The failure to ensure hazardous areas are protected by self-closing smoke resistive doors had the potential to affect all residents, staff, and visitors. ***Other Residents*** The failure to ensure hazardous areas are protected by self-closing smoke resistive doors has the potential to affect all residents, staff, and visitors.	5/2/14

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K 029	Continued From page 5 ensure hazardous areas are protected by self closing smoke resistive doors. Failure to protect the exit access corridor and main dining area could expose residents and staff to products of combustion before evacuation could occur. This deficient practice affected all residents, staff and visitors. The facility is licensed for 127 beds and had a census of 90 on the date of the survey. Findings include: During the facility tour on April 3, 2014 at approximately 1:15 PM it was observed that two doors and one serving window between the kitchen and the exit access corridor/main dining room were not self or automatic closing, and did not resist the passage of smoke as required when the sprinkler option is used. Further investigation could not accurately determine a fire rating of the wall, nor the required protected openings. One door from the preparation area, was labeled but without a labeled frame or self-closure, the other door was undetermined. The serving window was equipped with a accordion folding shutter, with openings at the top and bottom that would allow passage of smoke. Actual NFPA standard: LSC -2000 Definitions: 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	K 029	***Facility System*** The two doors between the kitchen and the main dining room will be equipped with self-closures by 4/25/14. The accordion-folding shutter will be replaced with a smoke-rated metal door that will close and seal during a fire. These smoke doors will be tested along with the facility fire doors to ensure they close during fire alarms and tests. The results of the tests will be recorded and any deficiencies will be repaired. For the accordion-folding shutter, a smoke rated door will need to be purchased, electrical power will need to be wired to that location, alarm signal will need to be wired to the door to respond during an alarm and the door jam will need to be replaced to accommodate the door track and trim. The facility has requested a six-month waiver to allow for the accordion-folding shutter project to be completed no later than 10/3/14. ***Quality Assurance and Monitoring*** The Environmental Services	

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K 029	Continued From page 6 appliances. 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 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 029	Director will report any findings to the Quality Improvement Meeting for further monitoring and plan modification if compliance is not met. ***Date of compliance*** May 2, 2014	
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily	K 038	**K 038** ***Resident Specific***	5/2/14

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K 038	Continued From page 7 accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based upon observation and interview the facility failed to ensure corridors were not used for storage and remain clear at all times. This deficient practice allowed for clutter in the corridor and can impede exit access in an emergency. This deficient practice affected 23 residents, all staff and visitors in the Syringa II unit. The facility is licensed for 127 beds and had a census of 90 on the date of the survey. Findings include: During the facility initital tour on April 3, 2014 at approximately 9:00 AM, observation revealed a table, med-cart, chair and a vacuum located in the corridor next to Syringa II nursing station. Later during the facility tour at approximately 3:30 PM observation revealed the facility had not relocated nor moved the above items. During the next 30 minutes observation continued without movement of the blocking items. During the exit conference at approximately 4:50 PM when describing the blockage of the corridor the Care Manager acknowledged this as common practice. Actual NFPA Standard: LSC -2000 19.2.1 General. Every aisle, passageway, corridor, exit discharge,	K 038	The failure to ensure the corridor was free and clear of storage had the potential to affect 23 residents, as well as staff and visitors on Syringa II. ***Other Residents*** The failure to ensure all corridors are free and clear of storage has the potential to affect all residents, staff and visitors. ***Facility System*** The table, med-cart, chair, and vacuum were cleared from the identified corridor on 4/4/14. In-servicing of staff on Syringa II regarding keeping corridors free and clear of storage will be completed by 4/25/14. Weekly inspections x4, Bi-Weekly inspections x2, and Monthly inspections x4 will be done by the Environmental Services Director to ensure all corridors are free and clear of storage items. ***Quality Assurance and Monitoring*** The Environmental Services Director will report any findings to the Quality Improvement Meeting	

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K 038	Continued From page 8 exit location, and access shall be in accordance with Chapter 7. Exception: As modified by 19.2.2 through 19.2.11. 7.1.10.2.1 No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress therefrom, or visibility thereof.	K 038	for further monitoring and plan modification if compliance is not met. ***Date of compliance*** May 2, 2014	
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based upon observation the facility failed to ensure complete sprinkler protection for exterior overhangs deeper than four feet of combustible construction. Failure to provide protection of overhangs allows fire to develop unchecked and spread into attic and interstitial spaces and can also block exits. This deficient practice affected two residents in Physical Therapy (PT), five staff, and three visitors in the PT wing at the time of the survey. The facility is licensed for 127 beds and	K 056	**K 056** ***Resident Specific*** The failure to ensure complete sprinkler protection for exterior overhangs deeper than four feet of combustible construction had the potential to affect two residents, five staff, and three visitors in the Physical Therapy (PT) wing. ***Other Residents*** The failure to ensure complete sprinkler protection for exterior overhangs deeper than four feet of combustible construction has the potential to affect all residents, staff, and visitors. ***Facility System*** There will need to be additional fire sprinklers added to the end of the sprinkler lines and will necessitate dry lines as the sprinkler system will be exposed to outside	5/2/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING	(X3) DATE SURVEY COMPLETED
	135085		04/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOISE VILLAGE	3115 SYCAMORE DRIVE BOISE, ID 83703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 056	Continued From page 9 had a census of 90 on the date of the survey. Findings include: During the facility tour on April 3, 2014 between 11:00 AM and noon, two exit overhangs were observed on the southern end of the PT wing not protected by automatic sprinklers. These overhangs provided weather protection for the two exits, one exiting to (east) the street, one to the (west) yard with a koi pond garden. The eastern overhang measured approximately 5 feet by 10 feet and was visually confirmed to be of combustible construction, the western overhang measured approximately 5 feet by 15 feet and was also visually confirmed to by of combustible construction. This deficiency was observed by surveyors and the Director of Environmental Services. Actual NFPA Standard: LSC - 2000 19.3.5.1 Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Exception: In Type I and Type II construction, where approved by the authority having jurisdiction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specified areas where the authority having jurisdiction has prohibited sprinklers, without causing a building to be classified as nonsprinklered. NFPA 13 - 1999	K 056	temperatures and will be susceptible to freezing in winter months. The new sprinkler lines will need to be added to the fire sprinkler inspection system currently in place. The ceiling at the end of the Therapy hall will need to be removed to allow access to the fire sprinkler system. Exterior sprinkler lines will need to be tied into the existing fire sprinkler system, and added through the exterior walls on either side of the hallway into the exterior threshold areas requiring sprinkler coverage. The facility has requested a six-month waiver to allow for this project to be completed no later than 10/3/14. ***Quality Assurance and Monitoring*** The Environmental Services Director will report any findings to the Quality Improvement Meeting for further monitoring and plan modification if compliance is not met. ***Date of compliance***	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING	(X3) DATE SURVEY COMPLETED
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K 056	Continued From page 10 5-13 Special Situations. 5-13.8* Exterior Roofs or Canopies. 5-13.8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 ft (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.	K 056	May 2, 2014	
K 074 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide window coverings with tags or labels indicating compliance with flammability requirements. This may expose residents, staff,	K 074	**K 074** ***Resident Specific*** The failure to provide window coverings with tags or labels indicating compliance with flammability requirements had the potential to affect residents, staff, and visitors in five of nine smoke compartments. ***Other Residents*** The failure to provide window coverings with tags or labels indicating compliance with flammability requirements has the potential to affect all residents, staff, and visitors. ***Facility System*** All window coverings identified were sprayed with a fire retardant spray on 4/3, 4/8 and 4/11 and were cataloged and dated with the treatment date.	5/2/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING	(X3) DATE SURVEY COMPLETED
	135085		04/03/2014

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K 074	Continued From page 11 and visitors to smoke and rapid fire growth potential, in five of nine smoke compartments. The facility is licensed for 127 beds and had a census of 90 on the date of the survey. Findings include: During facility tour on April 3, 2014 between 2:00 and 4:30 PM, inspection of the Music Therapy room found the window coverings did not have tags specifying compliance with flammability requirements. Further inspection elsewhere in the facility revealed honey comb type fabric window blinds which had no tag or label indicating flammability requirements. The number of blinds (greater than five rooms) discovered indicated the issue was widespread, and therefore further documentation was discontinued. This finding was discussed and acknowledged by the Director of Environmental Services during the exit conference. Actual NFPA Standard: LSC -2000 19.7.5.1* Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies shall be in accordance with the provisions of 10.3.1. (See 19.3.5.5.) Exception: Curtains at showers. 10.3.1* Where required by the applicable provisions of this Code, draperies, curtains, and other similar loosely hanging furnishings and decorations shall	K 074	Any new draperies, curtains, and other similar loosely hanging fabrics will be purchased that have been tested and tagged as meeting NFPA 701 standards. All appropriate departments were notified of this process on 4/25/14. ***Quality Assurance and Monitoring*** The Environmental Services Director will report any findings to the Quality Improvement Meeting for further monitoring and plan modification if compliance is not met. ***Date of compliance*** May 2, 2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING	(X3) DATE SURVEY COMPLETED
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K 074	Continued From page 12 be flame resistant as demonstrated by testing in accordance with NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films.	K 074		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 02 B. WING	(X3) DATE SURVEY COMPLETED
	MDS001060		04/03/2014

NAME OF PROVIDER OR SUPPLIER: GOOD SAMARITAN SOCIETY - BOISE VILLAGI

STREET ADDRESS, CITY, STATE, ZIP CODE: 3115 SYCAMORE DRIVE BOISE, ID 83703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	16.03.02 INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The facility is a single story, type V(111) construction with multiple additions and renovations. The most recent addition was completed in 2002 on the West side. A new complete fire alarm/smoke detection system was installed in 2001. The facility was originally built in 1957 and is fully sprinklered with the oldest portion of the building being demolished in 2007. Currently it is licensed for 127 SNF/NF beds. The following deficiencies were cited during the annual fire/life safety survey conducted on April 3, 2014. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70 and IDAPA 16.03.02 Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities. The Survey was conducted by: Mark Grimes, Supervisor Facility Fire Safety & Construction Program IDHW Dan Holbrook, Health Facility Surveyor, IDHW Sam Burbank, Health Facility Surveyor, IDHW	C 000	**General Disclaimer** 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. RECEIVED APR 18 2014 FACILITY STANDARDS	
C 226	02.106 FIRE AND LIFE SAFETY 106. FIRE AND LIFE SAFETY. Buildings on the premises used as facilities shall meet all the	C 226	**C 226** Refer to the Plan of Correction(s) for the following Federal "K" tags on	5/2/14

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 02 B. WING	(X3) DATE SURVEY COMPLETED
	MDS001060		04/03/2014

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C 226	Continued From page 1 requirements of local, state and national codes concerning fire and life safety standards that are applicable to health care facilities. This Rule is not met as evidenced by: Refer to deficiencies listed on the federal form 2567: K021 Smoke Barrier Door Close and Latch K025 Smoke Barrier Penetrations K029 Hazardous Areas K038 Blocked Corridor K056 Sprinkler Installation K074 Draperies and Curtains	C 226	the CMS-2567. K021 – Smoke Barrier Door Close and Latch K025 – Smoke Barrier Penetrations K029 – Hazardous Areas K038 – Blocked Corridor K056 – Sprinkler Installation K074 – Draperies and Curtains	