



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

CERTIFIED MAIL: 7007 3020 0001 4038 9802

November 4, 2014

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

Provider #: 135067

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

Dear Ms. Berg:

On **October 21, 2014**, a Facility Fire Safety and Construction survey was conducted at **Good Samaritan Society - Moscow Village** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies 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.

Jamie Berg, Administrator
November 4, 2014
Page 2 of 4

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 **November 17, 2014**. Failure to submit an acceptable PoC by **November 17, 2014**, may result in the imposition of civil monetary penalties by **December 7, 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 **November 25, 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 **November 25, 2014**. A change in the seriousness of the deficiencies on **November 25, 2014**, may result in a change in the remedy.

Jamie Berg, Administrator
November 4, 2014
Page 3 of 4

The remedy, which will be recommended if substantial compliance has not been achieved by **November 25, 2014**, includes the following:

Denial of payment for new admissions effective **January 21, 2015**.
42 CFR §488.417(a)

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **April 21, 2015**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Mark P. Grimes, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **October 21, 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:

Jamie Berg, Administrator
November 4, 2014
Page 4 of 4

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

Go to the middle of the page to Information Letters section and click on State and select the following:

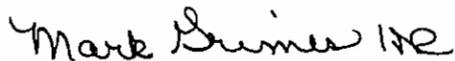
BFS Letters (06/30/11)

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

This request must be received by **November 17, 2014**. If your request for informal dispute resolution is received after **November 17, 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/pmt
Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 10/30/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135067	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/21/2014
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - MOSCOW VILL			STREET ADDRESS, CITY, STATE, ZIP CODE 640 NORTH EISENHOWER STREET MOSCOW, ID 83843	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The facility is a single story, Type II(111) building with a two hour horizontal exit separation from the independent apartment complex. The building was built in 1975 and is fully sprinklered. Currently, the facility is licensed for 64 SNF/NF beds. The following deficiencies were cited during the annual fire/life safety survey conducted on October 21, 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: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	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.	
K 029 SS=D	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 on observation, operational testing and interview, the facility failed to ensure that	K 029	K 029 SS=D 1. Self-closures were installed on door to Central Supply on 11/12/2014 and HIM office door on 11/14/2014. 2. All staff, visitors and 5 residents in 2 smoke compartments have the potential to be affected. 3. Facility maintenance staff will audit other facility doors to insure hazardous areas are protected by doors with self-closures. 4. Audit x 1. All audit findings will be reported to QAPI committee for further monitoring and modification.	RECEIVED OCT 27 2014 FACILITY COMPLIANCE November 25, 2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Sam Burbank

Administrator

11-14-14

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 029	<p>Continued From page 1</p> <p>hazardous areas were protected with self-closing doors. Failure to protect hazardous areas with self-closing doors would allow smoke and dangerous gases to pass freely into corridors affecting egress during a fire event. This deficient practice affected 5 residents, staff and visitors in 2 of 6 smoke compartments on the date of the survey. The facility is licensed for 64 SNF/NF beds and had a census of 51 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on October 21, 2014 from 10:30 AM to 12:30 PM, observation and operational testing of the doors from the corridor into the Central Supply and the Health Information Management (Medical Records) office found that neither door was equipped with a self-closing device. Further investigation found both rooms were over 100 square feet in size. Interview of the Director of Maintenance found he was not aware these two doors were required to self-close.</p> <p>Actual NFPA standard:</p> <p>3.3.13.2 Area, Hazardous. An area of a structure or building that poses a degree of hazard greater than that normal to the general occupancy of the building or structure, such as areas used for the storage or use of combustibles or flammables; toxic, noxious, or corrosive materials; or heat-producing appliances.</p> <p>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</p>	K 029		

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K 029	Continued From page 2 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		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This Standard is not met as evidenced by:	K 038	<p>K 038 SS=D</p> <ol style="list-style-type: none"> 1. Therapy/common bathroom deadbolt was removed and capped on 11/10/14. Staff/common restroom locks were replaced with inter-connect door hardware on 11/13/14. 2. All staff, visitors and residents utilizing common restrooms in 300 wing and physical therapy have the potential to be affected. 3. Facility maintenance staff will audit other facility common restroom doors to insure no additional locks are present. 4. Audit x 1. All audit findings will be reported to QAPI committee for further monitoring and modification. 	November 25, 2014

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K 038	<p>Continued From page 3</p> <p>Based on observation, operational testing and interview, the facility failed to maintain doors with a readily accessible means of exit. Failure to allow rapid means of exit access could potentially impede escape in the event of a fire or other emergency. This deficient practice affected residents, staff and visitors utilizing the common restroom in the 300 wing and the shower/bathroom in Physical Therapy on the date of the survey. The facility is licensed for 64 SNF/NF beds and had a census of 51 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on October 21, 2014 from 10:30 AM to 12:30 PM, the observation and operational testing of the doors into the common/shared restroom in the 300 wing and the shower/bathroom of Physical Therapy found both were equipped with deadbolts in addition to the primary door latch. When interviewed, the Director of Maintenance and staff in Physical Therapy indicated these were installed to maintain privacy for occupants.</p> <p>Actual NFPA standard:</p> <p>7.2.1.5.4*</p> <p>A latch or other fastening device on a door shall be provided with a releasing device having an obvious method of operation and that is readily operated under all lighting conditions. The releasing mechanism for any latch shall be located not less than 34 in. (86 cm), and not more than 48 in. (122 cm), above the finished floor. Doors shall be operable with not more than one releasing operation.</p> <p>Exception No. 1*: Egress doors from individual living units and guest rooms of residential</p>	K 038		

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K 038	Continued From page 4 occupancies shall be permitted to be provided with devices that require not more than one additional releasing operation, provided that such device is operable from the inside without the use of a key or tool and is mounted at a height not exceeding 48 in. (122 cm) above the finished floor. Existing security devices shall be permitted to have two additional releasing operations. Existing security devices other than automatic latching devices shall not be located more than 60 in. (152 cm) above the finished floor. Automatic latching devices shall not be located more than 48 in. (122 cm) above the finished floor. Exception No. 2: The minimum mounting height for the releasing mechanism shall not be applicable to existing installations.	K 038		
K 048 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 This Standard is not met as evidenced by: Based on record review and interview, the facility failed to ensure that staff was properly trained in the execution of the evacuation plan. Failure to implement and exercise the evacuation plan at least annually could result in staff not responding correctly during an emergency. This deficient practice affected 51 residents, staff and visitors in 5 of 5 smoke compartments on the date of the survey. The facility is licensed for 64 SNF/NF beds and had a census of 51 on the day of the survey. Findings include:	K 048	K 048 SS=F 1. Facility will conduct fire drill with evacuation of a smoke compartment before November 25, 2014. 2. 51 residents, staff and visitors in 5 of 5 smoke compartments have the potential to be affected. 3. Audit of documentation of fire drill with evacuation will be done to insure compliance. 4. Audit x 1. All audit findings will be reported to QAPI committee for further monitoring and modification.	November 25, 2014

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K 048	<p>Continued From page 5</p> <p>1) During record review of the facility conducted on October 21, 2014 from 8:30 AM to 9:30 AM, review of the facilities' fire drill records found no indication a partial or full evacuation of the facility residents had been conducted in the last 12 months.</p> <p>2) During the facility tour conducted on October 21, 2014 from 9:30 AM to 12:00 PM, interview of CNA staff in both the 100 wing and the 200 wing found they could not recall the last time a full or partial evacuation drill had been conducted.</p> <p>3) During the exit conference conducted on October 21, 2014 from 12:00 PM to 12:45 PM, interview of both the Administrator and the Director of Maintenance revealed the facility had not conducted its required annual evacuation drill.</p> <p>Actual NFPA standard:</p> <p>19.7.1.1 The administration of every health care occupancy shall have, in effect and available to all supervisory personnel, written copies of a plan for the protection of all persons in the event of fire, for their evacuation to areas of refuge, and for their evacuation from the building when necessary. All employees shall be periodically instructed and kept informed with respect to their duties under the plan. A copy of the plan shall be readily available at all times in the telephone operator ' s position or at the security center. The provisions of 19.7.1.2 through 19.7.2.3 shall apply.</p>	K 048		
K 075 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space</p>	K 075		

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K 075	<p>Continued From page 6</p> <p>does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure highly combustible material was stored in a safe manner. Failure to provide proper protection of hazardous storage would result in smoke and dangerous gases passing freely into corridors during a fire hindering egress capabilities. This deficient practice affected all residents, staff and visitors utilizing the Physical Therapy portion of the 100 wing on the date of the survey. The facility is licensed for 64 SNF/NF beds and had a census of 51 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on October 21, 2014 from 10:30 AM to 12:30 PM, observation of the exit access corridor located in the Physical Therapy section of the 100 wing found (2) over 32 gal. receptacles for soiled linen and trash stored in less than 64 square feet. When asked, the Director of Maintenance stated he was not aware of why these receptacles were being stored in this location.</p> <p>Interview of Physical Therapy staff revealed that these receptacles were moved into this location</p>	K 075	<p>K 075 SS=E</p> <ol style="list-style-type: none"> 1. Staff using therapy bathroom/shower room will move 1 barrel into therapy department to ensure 8 ft. separation. 2. All residents, staff and visitors utilizing the physical therapy portion of the 100 wing have the potential to be affected. 3. Therapy staff and nursing staff will be educated regarding procedure for barrel separation. 4. Audit weekly x 4 and monthly x 1. All audit findings will be reported to QAPI committee for further monitoring and modification. 	November 25, 2014

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K 075	<p>Continued From page 7 during the time when the shower room was in use.</p> <p>Actual NFPA standard:</p> <p>19.7.5.5 Soiled linen or trash collection receptacles shall not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gal/ft² (20.4 L/m²). A capacity of 32 gal (121 L) shall not be exceeded within any 64-ft² (5.9-m²) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) shall be located in a room protected as a hazardous area when not attended. Exception: Container size and density shall not be limited in hazardous areas.</p>	K 075		
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Bureau of Facility Standards

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C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The facility is a single story, Type II(111) building with a two hour horizontal exit separation from the independent apartment complex. The building was built in 1975 and is fully sprinklered. Currently, the facility is licensed for 64 SNF/NF beds.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on October 21, 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.</p> <p>The survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	C 000	<p>Preparation and Execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations manual.</p>	
C 226	<p>02.106 FIRE AND LIFE SAFETY</p> <p>106. FIRE AND LIFE SAFETY. Buildings on the premises used as facilities shall meet all the requirements of local, state and national codes concerning fire and life safety standards that are applicable to health care facilities.</p> <p>This Rule is not met as evidenced by: Please refer to "K" tags on CMS 2567:</p> <p>K 029 Hazardous area protection K 038 Exit access capability K 048 Evacuation drills</p>	C 226	<p>C 226 Please refer to response for K 029, K 038, K048, K075.</p> <p>NOV 17 2014</p> <p>RECEIVED</p> <p>FACILITY STANDARDS</p>	November 25, 2014

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

J. Bey

TITLE

Administrator

(X6) DATE

11-17-14

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135067	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/21/2014
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - MOSCOW VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 640 NORTH EISENHOWER STREET MOSCOW, ID 83843		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 226	Continued From Page 1 K 075 Combustible material storage	C 226		