



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 4051 1234

November 6, 2013

David Bargmann, 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. Bargmann:

On **October 31, 2013**, 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 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

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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 19, 2013**. Failure to submit an acceptable PoC by **November 19, 2013**, may result in the imposition of civil monetary penalties by **December 9, 2013**.

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 **December 5, 2013**, (Opportunity to Correct). Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **December 5, 2013**. A change in the seriousness of the deficiencies on **December 5, 2013**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **December 5, 2013**, includes the following:

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Denial of payment for new admissions effective **January 31, 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 **May 1, 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 **October 31, 2013**, 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>

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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 19, 2013**. If your request for informal dispute resolution is received after **November 19, 2013**, 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

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

Printed: 11/06/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135058	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/31/2013
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - SILVER WOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 405 WEST SEVENTH STREET SILVERTON, ID 83867	
(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 (III) fully sprinklered structure built in 1975. A complete fire alarm system is in place. There is an assisted living wing with adjacent independent retirement wing with a two (2) hour fire wall separation between assisted living/skilled nursing and independent. The facility is currently licensed for 50 beds. The following deficiencies were cited during the annual life safety code survey conducted on October 31, 2013. 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: Tom Mroz CFI-II Health Facility Surveyor Facility Fire/Life Safety & Construction Program	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 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:	K 025	K025 1. Potential smoke passage ways will be closed. 2. This deficiency affected all staff and 35 residents. 3. Covers were put in place to block the passage of smoke.	

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

TITLE

(X6) DATE



Administrator

11/13/13

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 025	<p>Continued From page 1</p> <p>Based on observation and interview, the facility failed to assure that all smoke barriers would provide protection against passage of smoke between smoke compartments. Openings in smoke barriers can allow smoke and fire gasses to enter other smoke compartments in the event of a fire. This deficient practice affected staff and approximately 26 residents in two of five smoke compartments. The facility has the capacity for 50 beds with a census of 35 the day of survey.</p> <p>Findings include:</p> <p>1.) During the facility tour on 10/31/13 at 10:29 a.m., it was observed that the north mechanical room had an approximately 2' x 2' open ceiling that would allow the passage of smoke in the event of a fire. Interview with the facility maintenance engineer revealed the facility was performing repairs above the ceiling four days ago and had yet to close the opening..</p> <p>2.) During the facility tour on 10/31/13 at 10:45 a.m., revealed an approximately one unsealed penetration around a ceiling HVAC duct that was missing the diffuser in the mechanical/data/electric panel. Interview with the facility maintenance engineer revealed that the facility was not aware the missing diffuser created an unsealed penetration in the smoke barrier ceiling.</p> <p>Actual NFPA Standards: NFPA 101, 19.3.7.3. Smoke barriers shall provide at least a one half hour fire resistance rating. NFPA 101, 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</p>	K 025	<p>4. Education done with maintenance department regarding the need to ensure all penetration points are sealed.</p> <p>5. Compliance on or before 11/13/13</p>	

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K 025	Continued From page 2 or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces. NFPA 101. 8.3.6 Penetrations and Miscellaneous Openings in Floors and Smoke Barriers. 8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: (1) The space between the penetrating item and the smoke barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (2) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (3) Where designs take transmission of vibration into consideration, any vibration isolation shall meet one of the following conditions: a. It shall be made on either side of the smoke barrier. b. It shall be made by an approved device that is designed for the specific purpose.	K 025		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under	K 050		

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K 050	<p>Continued From page 3</p> <p>varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>This Standard is not met as evidenced by: Based on record review, and interview, the facility failed to provide documented fire drills for each shift during each quarter for the last twelve months. Failure to train and exercise personnel in emergency procedures could result in panic and confusion in a true emergency. The deficient practice affected all five smoke compartments, staff, and all residents. The facility has the capacity for 50 beds and at the time of the survey the census was 35.</p> <p>Findings include:</p> <p>During record review of the facility's fire drill reports for the 12 month period preceding the survey on 10/31/13 at 9:35a.m., the facility was unable to provide a documented fire drill for the third shift in the third quarter of 2013. Interview with the maintenance engineer revealed the facility was aware the drill had not been performed.</p> <p>Actual NFPA Standard: NFPA 101, 19.7.1.2. 19.7.1.2 Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills</p>	K 050	<p>K050</p> <ol style="list-style-type: none"> 1. Fire drills will be done quarterly for each shift. 2. This deficiency affected all staff and 35 residents. 3. Environmental Services assistant has been trained to conduct fire drills and will serve as back up. Also reminders put into preventative maintenance application and will be automatically put on punch list. 4. A preventative maintenance schedule will be implemented to ensure fire drills are done quarterly for each shift. 5. Compliance on or before 11/13/13. 	

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K 050	Continued From page 4 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. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms.	K 050		
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C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>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.</p> <p>The facility is a single story, type V (III) fully sprinklered structure built in 1975. A complete fire alarm system is in place. There is an assisted living wing with adjacent independent retirement wing with a two (2) hour fire wall separation between assisted living/skilled nursing and independent. The facility is currently licensed for 50 beds.</p> <p>The following deficiencies were cited during the annual life safety code survey conducted on October 31, 2013. The facility was surveyed under IDAPA 16.03.02, Rules, and Minimum Standards for Skilled Nursing and Intermediate Care Facilities.</p> <p>The survey was conducted by:</p> <p>Tom Mroz CFI-II Health Facility Surveyor Facility Fire/Life Safety & Construction Program</p>	C 000		
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. This RULE: is not met as evidenced by: Refer to the following Federal "K" tags on the CMS - 2567:</p> <p>1. K050 Fire Drill</p>	C 226	<p>See POC for K050 and K025</p>	

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If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

TITLE

(X6) DATE



Administrator

11/13/13

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C 226	Continued From Page 1 2. K025 Penetrations	C 226		

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.