



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

TAMARA PRISOCK – ADMINISTRATOR  
DIVISION OF LICENSING & CERTIFICATION  
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

April 28, 2017

Julie Johansen, 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 Ms. Johansen:

On **April 19, 2017**, 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

Julie Johansen, Administrator

April 28, 2017

Page 2 of 4

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 **May 11, 2017**. Failure to submit an acceptable PoC by **May 11, 2017**, may result in the imposition of civil monetary penalties by **May 31, 2017**.

Your PoC must contain the following:

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

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **May 24, 2017**, (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 24, 2017**. A change in the seriousness of the deficiencies on **May 24, 2017**, may result in a change in the remedy.

Julie Johansen, Administrator  
April 28, 2017  
Page 3 of 4

The remedy, which will be recommended if substantial compliance has not been achieved by **May 24, 2017**, includes the following:

Denial of payment for new admissions effective **July 19, 2017**.  
42 CFR §488.417(a)

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **October 19, 2017**, if substantial compliance is not achieved by that time.

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

If you believe these deficiencies have been corrected, you may contact Nate Elkins, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, option 3; Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **April 19, 2017**, 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:

Julie Johansen, Administrator  
April 28, 2017  
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:

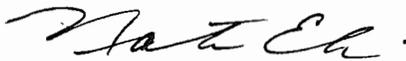
BFS Letters (06/30/11)

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

This request must be received by **May 11, 2017**. If your request for informal dispute resolution is received after **May 11, 2017**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626, option 3.

Sincerely,



Nate Elkins, Supervisor  
Facility Fire Safety and Construction

NE/lj  
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135058</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/19/2017</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER <b>GOOD SAMARITAN SOCIETY - SILVER WOOD</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>405 WEST SEVENTH STREET SILVERTON, ID 83867</b>
---	---

(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	<p><b>INITIAL COMMENTS</b></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 April 19, 2017. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.</p> <p>The survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety &amp; Construction</p>	K 000	<p style="text-align: center;">MAY 08 2017 FACILITY</p> <p>K211</p> <p>1. What corrective action will be taken: A spread sheet with all rated door Assemblies have been created to include: Door leaves equipped with panic hardware; Door assemblies in exit enclosures; electronically Controlled egress doors; Door assemblies with special locking arrangements (Fire rated door assemblies). Please see the attached spread sheet Exhibit #1. All residents and staff have the potential to be affected.</p> <p>2. Spread sheet with all door assemblies And hardware has been developed for use in the Annual testing and inspection. Please see Exhibit #1.</p> <p>3. Maintenance director will complete The annual testing and inspection as required. Results will be reported to the QAPI committee. The administrator will ensure ongoing compliance.</p> <p>Date of compliance: 05/05/2017</p>	
K 211 SS=F	<p><b>NFPA 101 Means of Egress - General</b></p> <p>Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This Standard is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure that fire rated assemblies were inspected in accordance with NFPA 80 or NFPA 105, as applicable. Failure to inspect and test the smoke or fire resistive properties of doors as designed, could result in a lack of system performance during a fire. This</p>	K 211		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>Surveyor</b>	(X6) DATE <b>5/5/2017</b>
---	--------------------------	------------------------------

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135058</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/19/2017</b>
NAME OF PROVIDER OR SUPPLIER <b>GOOD SAMARITAN SOCIETY - SILVER WOOD</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>405 WEST SEVENTH STREET SILVERTON, ID 83867</b>		
(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 211	<p>Continued From page 1</p> <p>deficient practice affected 40 residents, staff and visitors on the date of the survey. The facility is licensed for 50 SNF/NF beds and had a census of 40 on the day of the survey.</p> <p>Findings include:</p> <p>1) During review of provided facility annual inspection records conducted on April 19, 2017 from approximately 9:00 AM to 10:00 AM, no record was available demonstrating an initial inspection and testing of rated assemblies had been conducted. When asked about the missing documentation, the Maintenance Manager stated he was not aware of this requirement.</p> <p>2) During the facility tour conducted on April 19, 2017 from approximately 10:00 AM to 12:30 PM, observation of installed doors revealed doors in the facility were tagged with fire labels ranging from 20 to 30 minutes fire resistive construction.</p> <p>Actual NFPA standard:</p> <p>NFPA 101</p> <p>19.2 Means of Egress Requirements 19.2.2.2 Doors. 19.2.2.2.1 Doors complying with 7.2.1 shall be permitted.</p> <p>7.2.1 Door Openings. 7.2.1.15 Inspection of Door Openings. . 7.2.1.15.1* Where required by Chapters 11 through 43, the following door assemblies shall be inspected and tested not less than annually in accordance with 7.2.1.15.2 through 7.2.1.15.8: (1) Door leaves equipped with panic hardware or fire exit hardware in accordance with 7.2.1.7</p>	K 211		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135058</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/19/2017</b>
NAME OF PROVIDER OR SUPPLIER <b>GOOD SAMARITAN SOCIETY - SILVER WOOD</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>405 WEST SEVENTH STREET SILVERTON, ID 83867</b>		
(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 211	Continued From page 2 (2) Door assemblies in exit enclosures (3) Electrically controlled egress doors (4) Door assemblies with special locking arrangements subject to 7.2.1.6  7.2.1.15.2 Fire-rated door assemblies shall be inspected and tested in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Smoke door assemblies shall be inspected and tested in accordance with NFPA 105, Standard for Smoke Door Assemblies and Other Opening Protectives.  NFPA 80 5.2* Inspections. 5.2.1* Fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ.  NFPA 105 5.2 Specific Requirements. 5.2.1* Inspections. 5.2.1.1 Smoke door assemblies shall be inspected annually. 5.2.1.2 Doors shall be operated to confirm full closure. 5.2.1.3 Hardware and gaskets shall be inspected annually, and any parts found to be damaged or inoperative shall be replaced.	K 211		
K 223 SS=D	NFPA 101 Doors with Self-Closing Devices  Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of:	K 223	K223  1. What corrective Action has been accomplished: The drop door stop on the housekeeping storage has been removed according to NFPA 101 19.2.2.2.7 Doors with Self-Closing Devices. 2. How will you identify Others having potential to be Affected: All occupants of the Building including staff have the potential to be affected. 3. What measures /systematic Changes will be put in place to ensure There is not a recurrence: Maintenance Will check on weekly rounds; The Administrator will ensure on-going compliance. <b>Exh #5</b> 4. Date of Compliance: 05/05/2017	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135058</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/19/2017</b>
NAME OF PROVIDER OR SUPPLIER <b>GOOD SAMARITAN SOCIETY - SILVER WOOD</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>405 WEST SEVENTH STREET SILVERTON, ID 83867</b>		
(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 223	<p>Continued From page 3</p> <ul style="list-style-type: none"> <li>* Required manual fire alarm system; and</li> <li>* Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</li> <li>* Automatic sprinkler system, if installed; and</li> <li>* Loss of power.</li> </ul> <p>18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8</p> <p>This Standard is not met as evidenced by: Based on observation and operational testing, the facility failed to ensure doors equipped with self-closing devices were not held open by a non-automatic releasing device. Hold-open devices used on self-closing doors not interconnected to the fire alarm or suppression system, could allow smoke and dangerous gases to enter corridors, affecting the egress of residents. This deficient practice affected 5 residents, staff and visitors on the date of the survey. The facility is licensed for 50 SNF/NF beds and had a census of 40 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on April 19, 2017 from approximately 10:00 AM to 12:30 PM, observation and operational testing of the door to the Housekeeping storage in the 100 hall revealed the door was equipped with a drop-down door stop. Further observation revealed the room was approximately ten feet by fourteen feet (140 square feet) and housed combustibles of toilet paper; paper towels and chemicals. When asked about the door hold-open device, the Maintenance Manager stated he was not aware why it was installed as staff was not allowed to hold the door open.</p> <p>Actual NFPA standard:</p>	K 223		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135058</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/19/2017</b>
NAME OF PROVIDER OR SUPPLIER <b>GOOD SAMARITAN SOCIETY - SILVER WOOD</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>405 WEST SEVENTH STREET SILVERTON, ID 83867</b>		
(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 223	Continued From page 4 19.2.2.2.7* Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier, or hazardous area enclosure shall be permitted to be held open only by an automatic release device that complies with 7.2.1.8.2. The automatic sprinkler system, if provided, and the fire alarm system, and the systems required by 7.2.1.8.2, shall be arranged to initiate the closing action of all such doors throughout the smoke compartment or throughout the entire facility.	K 223		
K 324 SS=D	NFPA 101 Cooking Facilities  Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2  This Standard is not met as evidenced by: Based on observation and interview, the facility	K 324	K324 1. What corrective action will Be accomplished: The three protective caps for the pendants on the exhaust hood fire suppression system pendants were put back in place. In accordance with NFPA 17A 4.3.1.5 All discharge nozzles are provided with caps or other suitable devices to prevent the entrance of grease vapors moisture, or other foreign materials into the piping. Please see Exhibit # <u>2</u> . 2. All occupants and staff Have the potential to be affected. 3. Systematic changes put into Place; Maintenance and the DSM will monitor. The administrator will ensure ongoing compliance. <i>Exhibit 15</i> 4. Date of Compliance: 05/05/2017	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135058</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/19/2017</b>
NAME OF PROVIDER OR SUPPLIER <b>GOOD SAMARITAN SOCIETY - SILVER WOOD</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>405 WEST SEVENTH STREET SILVERTON, ID 83867</b>		
(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 324	<p>Continued From page 5</p> <p>failed to ensure cooking exhaust hood suppression systems were maintained in accordance with NFPA 96 and NFPA 17A. Failure to replace the protective caps for suppression system pendants in exhaust hoods, could allow grease laden vapors to coat system components and impede the operation of the system during a fire. This deficient practice affected staff and vendors of the main Kitchen on the date of the survey. The facility is licensed for 50 SNF/NF beds and had a census of 40 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on April 19, 2017 from approximately 1:00 PM to 2:00 PM, observation of the exhaust hood fire suppression system pendants revealed three of three protective caps for the pendants were not in place. Interview of the dietary staff revealed they were not aware these caps were required to be in place to protect the pendants.</p> <p>Actual NFPA standard:</p> <p>NFPA 96</p> <p>10.2.6 Automatic fire-extinguishing systems shall be installed in accordance with the terms of their listing, the manufacturer ' s instructions, and the following standards where applicable:</p> <p>(1) NFPA 12 (2) NFPA 13 (3) NFPA 17 (4) NFPA 17A</p> <p>NFPA 17A</p> <p>4.3.1.5 All discharge nozzles shall be provided</p>	K 324		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135058</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02 - ENTIRE BUILDING</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/19/2017</b>
NAME OF PROVIDER OR SUPPLIER <b>GOOD SAMARITAN SOCIETY - SILVER WOOD</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>405 WEST SEVENTH STREET SILVERTON, ID 83867</b>		
(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 324	Continued From page 6 with caps or other suitable devices to prevent the entrance of grease vapors, moisture, or other foreign materials into the piping.	K 324		
K 918 SS=F	NFPA 101 Electrical Systems - Essential Electric System  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 and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This Standard is not met as evidenced by:	K 918	K918  1. Corrective action that has been accomplished: Cummings Diesel came out to the Facility. The Generator maintenance and workings were taught to maintenance personnel. A monthly load test was completed. Maintenance was taught and shown how to do the monthly load test. A tracking sheet for monthly load Testing was put in place. Please see the Attached monthly tracking sheet And the report from Cummins Diesel (Exhibit # <del>3</del> #34).  2. All residents and staff have the potential to be affected.  3. Systematic changes put in place: Maintenance personnel to complete monthly load test and tracking paperwork.  4. Administrator will check monthly Paperwork and ensure compliance.  Date of Compliance: 05/05/2017	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135058</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/19/2017</b>
NAME OF PROVIDER OR SUPPLIER <b>GOOD SAMARITAN SOCIETY - SILVER WOOD</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>405 WEST SEVENTH STREET SILVERTON, ID 83867</b>		
(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 918	<p>Continued From page 7</p> <p>Based on record review and interview, the facility failed to ensure Emergency Power Supply Systems (EPSS) were maintained in accordance to NFPA 110. Failure to inspect and test generators could hinder early detection of system problems and the performance of the equipment during an emergency. This deficient practice affected 40 residents, staff and visitors on the date of the survey. The facility is licensed for 50 SNF/NF beds and had a census of 40 on the day of the survey.</p> <p>Findings include:</p> <p>During review of the EPSS inspection and testing documentation provided on April 19, 2017 from approximately 9:00 AM 10:00 AM, no records for monthly load tests were provided. When asked about the missing documentation, the Maintenance Manager stated he was not aware of the requirement to test the generator load monthly prior to the date of the survey.</p> <p>Actual NFPA standard:</p> <p>NFPA 110</p> <p>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.</p> <p>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</p>	K 918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135058</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02</b> - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/19/2017</b>
NAME OF PROVIDER OR SUPPLIER <b>GOOD SAMARITAN SOCIETY - SILVER WOOD</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>405 WEST SEVENTH STREET SILVERTON, ID 83867</b>		
(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 918	Continued From page 8 kW rating	K 918		
K 923 SS=D	NFPA 101 Gas Equipment - Cylinder and Container Storage  Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)	K 923	K923  1. Corrective Action taken to correct the Deficient practice: Signage has been posted in the oxygen storage Room identifying full O2 cylinders and empty O2 cylinders. Please see Exhibit # <u>4</u> . 2. How will you identify others having Potential to be affected by this deficient practice: All occupants of the building including staff have the potential of being affected. 3. What measures or changes will be put In place to correct: Signage is place (Exhibit # <u>4</u> );  4. How will corrective action be monitored: Maintenance will monitor signs are in place on daily rounds. Results will be reported to the QAPI committee. Administrator will ensure compliance. <u>Exh #5</u> Date of compliance: 05/05/2017	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135058</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/19/2017</b>
NAME OF PROVIDER OR SUPPLIER <b>GOOD SAMARITAN SOCIETY - SILVER WOOD</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>405 WEST SEVENTH STREET SILVERTON, ID 83867</b>		
(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 923	<p>Continued From page 9</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure medical gases were stored in accordance with NFPA 99. Failure to segregate empty oxygen cylinders from full could result in using incorrect cylinders during an emergency. This deficient practice affected 5 residents, staff and visitors on the date of the survey. The facility is licensed for 50 SNF/NF beds and had a census of 40 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on April 19, 2017 from approximately 10:30 AM to 12:30 PM, observation of the oxygen storage room in the 100 hall revealed twenty-four (24) "E" cylinders and six (6) M6 cylinders stored in racks with no designation as to if the cylinders were full or empty. When asked how full cylinders were identified from empty, the Maintenance manager stated he was not sure how cylinders were identified, or the requirement to segregate full from empty cylinders.</p> <p>Actual NFPA standard:</p> <p>NFPA 99</p> <p>11.6.5 Special Precautions - Storage of Cylinders and Containers.</p> <p>11.6.5.1 Storage shall be planned so that cylinders can be used in the order in which they are received from the supplier.</p> <p>11.6.5.2 If empty and full cylinders are stored within the same enclosure, empty cylinders shall be segregated from full cylinders.</p> <p>11.6.5.3 Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed in a rapid manner.</p>	K 923		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135058</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/19/2017</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER <b>GOOD SAMARITAN SOCIETY - SILVER WOOD VILL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>405 WEST SEVENTH STREET SILVERTON, ID 83867</b>
--	---

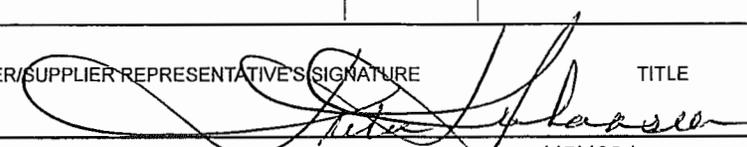
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

C 000	<p>16.03.02 INITIAL COMMENTS</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 living. The facility is currently licensed for 50 beds.</p> <p>The following deficiencies were cited during the annual life safety code survey conducted on April 19, 2017. The facility was surveyed under the LIFE SAFETY CODE, 2012 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/Life Safety &amp; Construction</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.</p> <p>This Rule is not met as evidenced by: Please refer to CMS "K" tags:</p>	C 226		

MAY 03 2017  
FACILITY STANDARDS

Idaho form

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



TITLE

(X6) DATE

5/5/2017

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135058</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/19/2017</b>
NAME OF PROVIDER OR SUPPLIER <b>GOOD SAMARITAN SOCIETY - SILVER WOOD VILL</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>405 WEST SEVENTH STREET SILVERTON, ID 83867</b>		
(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-211 Rated assembly maintenance and testing K-223 Self-closing doors K-324 Exhaust hood maintenance K-918 Generator testing and maintenance K-923 Medical gas storage	C 226	<i>Please refer to K-211 Please refer to K-223 Please refer to K-324 Please refer to K-918 Please refer to K-923</i>	
C 445	02.120,13,c  c. The temperature of hot water at plumbing fixtures used by patients/residents shall be between one hundred five degrees (105F) and one hundred twenty degrees (120F) Fahrenheit. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure that water temperature were maintained between 105 degrees and 120 degrees. Failure to provide water temperatures in accordance to the rule, could result in accidental scalding during routine washing or scheduled therapy bathing. This deficient practice affected 40 residents, staff and visitors on the date of the survey. The facility is licensed for 50 SNF/NF beds and had a census of 40 on the date of the survey.  Findings include:  During the facility tour conducted on April 19, 2017 from approximately 10:00 AM to 2:30 PM, observation of water temps taken in five resident room locations, revealed all five locations had water temperatures exceeding 120 degrees. When asked, the Maintenance Supervisor stated he was not aware the water temperatures were over 120 degrees.  Actual IDAPA standard:	C 445	The temperature of the hot water at plumbing fixtures Has consistently been between 105 - 120 degrees Please see Exhibit #6 and #6-1.  Findings will be reported to QAPI committee. Maintenance will monitor.  Date of Completion 5-5-2017	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135058</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/19/2017</b>
NAME OF PROVIDER OR SUPPLIER <b>GOOD SAMARITAN SOCIETY - SILVER WOOD VILL</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>405 WEST SEVENTH STREET SILVERTON, ID 83867</b>		
(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 445	Continued From Page 2  IDAPA 16.03.11.120.13 (c)  c. The temperature of hot water at plumbing fixtures used by patients/residents shall be between one hundred five degrees (105F) and one hundred twenty degrees (120F) Fahrenheit	C 445		