



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR  
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P.O. Box 83720  
Boise, Idaho 83720-0009  
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May 25, 2017

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

Provider #: 135067

Dear Ms. Berg:

On **May 18, 2017**, a survey was conducted at Good Samaritan Society - Moscow Village by the Idaho Department of Health and Welfare, Division of Licensing and Certification, 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/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated 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. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct." **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

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After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **June 4, 2017**. Failure to submit an acceptable PoC by **June 4, 2017**, may result in the imposition of penalties by **June 29, 2017**.

The components of a Plan of Correction as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained; and
- Include dates when corrective action will be completed in column (X5).

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

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 **June 22, 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 **August 16, 2017**. A change in the seriousness of the deficiencies on **July 2, 2017**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **August 16, 2017** includes the following:

Denial of payment for new admissions effective **August 16, 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 non-compliance, 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 **November 14, 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, CMS will provide you with a separate formal notification of that determination.**

If you believe these deficiencies have been corrected, you may contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; fax number: (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 **August 16, 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:

<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 **June 4, 2017**. If your request for informal dispute resolution is received after **June 4, 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, comments or concerns, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2.

Sincerely,

A handwritten signature in black ink that reads "D. Scott". The signature is written in a cursive, slightly slanted style.

David Scott, R.N., Supervisor  
Long Term Care

DS/lj  
Enclosures

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

PRINTED: 06/08/2017  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135067</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/18/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - MOSCOW VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>640 NORTH EISENHOWER STREET MOSCOW, ID 83843</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	
F 000	INITIAL COMMENTS  The following deficiencies were cited during the federal recertification survey conducted at the facility from May 15, 2017 to May 18, 2017.  The surveyors conducting the survey were:  Jenny Walker, RN, Team Coordinator Susan Costa, RN  Abbreviations:  CHF = Congestive Heart Failure DNS = Director of Nursing l/m = liter per minute LPN = Licensed Practical Nurse MAR = Medication Administration Record RN = Registered Nurse TAR = Treatment Administration Record	F 000			
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  (b)(3) Comprehensive Care Plans  The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-  (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure treatments were not provided without a physician's order. This was true for 1 of 11 (#3) residents reviewed for oxygen therapy and had the potential for harm if residents received medications and/or treatments without a	F 281	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	6/22/17	

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

TITLE

(X6) DATE

Electronically Signed

05/31/2017

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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F 281	<p>Continued From page 1</p> <p>physician's order. Findings included:</p> <p>Resident #3 was admitted to the facility on 4/7/17 with multiple diagnoses, including and readmitted to the facility on 5/2/17, with multiple diagnoses, including CHF and pneumonia.</p> <p>Resident #3's May 2017 Physician Order Summary Report did not include orders for oxygen therapy.</p> <p>Resident #3's clinical record did not include a May 2017 care plan for oxygen therapy.</p> <p>Neither Resident #3's MAR nor TAR , dated 5/2/17 to 5/16/17, included oxygen therapy.</p> <p>Nurse Progress Notes and a Weights and Vitals Summary Report both documented Resident #3 received oxygen daily via nasal cannula from 5/2/17 through 5/18/17.</p> <p>Resident #3 was observed receiving oxygen at 1 l/m via nasal cannula on 5/15/17 at 2:30 pm; 5/16/17 at 8:10 am, 9:00 am, and 2:35 pm; and on 5/17/17 at 8:50 am and 9:20 am.</p> <p>On 5/18/17 at 10:45 am, the DNS said hospital discharge orders for oxygen at 1 l/m via nasal cannula was not transcribed to the facility's admission orders.</p> <p>On 5/18/17 at 11:00 am, LPN [Licensed Practical Nurse] #1 said Resident #3 was re-admitted from a hospital on 5/2/17 with orders for oxygen therapy via nasal cannula. LPN #1 said she did not realize there was not an order or care plan for oxygen therapy.</p>	F 281	<p>solely because it is required by the provisions of Federal and State law. For the purposes of any allegation that the facility is not insubstantial 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> <ol style="list-style-type: none"> <li>1. Resident #3's orders, care plan, and TAR were updated to include oxygen therapy.</li> <li>2. All residents receiving O2 have the potential to be affected and will have their orders, TARS, and care plans audited to ensure compliance.</li> <li>3. The QAPI Team determined the root cause of the deficiency was the lack of a thorough review of all documents received when the resident was readmitted. All LNs and HIM staff will be re-educated on reviewing all documents during an admission to ensure nothing is missed.</li> <li>4. The DNS or designee will audit the orders, TARs, and care plans for all new admissions weekly X 4 and monthly X 1. All findings will be reported to the QAPI Committee for further monitoring and modification.</li> </ol>		

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

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NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - MOSCOW VILLAGE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>640 NORTH EISENHOWER STREET MOSCOW, ID 83843</b>		
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F 281	Continued From page 2  On 5/18/17 at 11:30 am, RN #1 said she did not see the hospital oxygen therapy order for Resident #3 because it was on a separate page from other discharge orders.	F 281		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001510</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/18/2017</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - MOSCOW VILL.</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>640 NORTH EISENHOWER STREET MOSCOW, ID 83843</b>
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C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The following deficiencies were cited during the state re-licensure survey conducted at the facility from May 15, 2017 to May 18, 2017.</p> <p>The surveyors conducting the survey were:</p> <p>Jenny Walker, RN, Team Coordinator Susan Costa, RN</p> <p>Abbreviations:</p> <p>RN = Registered Nurse</p>	C 000		
C 664	<p>02.150,02,a Required Members of Committee</p> <p>a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative. This Rule is not met as evidenced by: Based on review of Quality Assurance Performance Improvement meeting minutes and staff interview, it was determined the facility failed to ensure the pharmacist participated in the facility's Infection Control Meetings at least quarterly. This failure created the potential for negative outcomes for residents, visitors, and staff in the facility related to the prevention of infections and disease. Findings included:</p> <p>On 5/17/17 at 11:45 am, the Infection Control Program was reviewed with RN #1. RN #1 said the facility held its Quality Assurance Performance Improvement meetings on a monthly basis and infection control was a</p>	C 664	<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 insubstantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section</p>	6/22/17

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Electronically Signed	TITLE	(X6) DATE <b>05/31/17</b>
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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001510</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/18/2017</b>
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C 664	<p>Continued From page 1</p> <p>component of those meetings.</p> <p>RN #1 provided attendance records, dated 1/31/17, 2/28/17, 3/28/17, and 4/25/17, that documented a pharmacist failed to attend the Infection Control meetings.</p> <p>On 5/17/17 at 11:45 am, RN #1 stated she was not aware the pharmacist was required to attend the facility's Infection Control meetings.</p>	C 664	<p>7305 of the State Operations manual.</p> <ol style="list-style-type: none"> <li>1. N/A - no residents were identified.</li> <li>2. All residents have the potential to be affected by the pharmacist's lack of participation. The pharmacist will be added to the Infection Control Meeting participant list.</li> <li>3. The QAPI Team determined that the root cause of the deficiency was the facility's lack of awareness of the requirement. The QAPI/Infection Control Committee will be educated on the requirement/regulation.</li> <li>4. The QAPI Coordinator or designee will audit the QAPI/Infection Control Meeting/minutes to ensure the pharmacist attends quarterly x 3 quarters. All findings will be reported to the QAPI Committee for further monitoring and modification.</li> </ol>	