



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSSELL S. BARRON – 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

March 29, 2018

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 **March 21, 2018**, 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. 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

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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 **April 11, 2018**. Failure to submit an acceptable PoC by **April 11, 2018**, may result in the imposition of civil monetary penalties by **May 1, 2018**.

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 may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **April 25, 2018**, (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 **April 25, 2018**. A change in the seriousness of the deficiencies on **April 25, 2018**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by

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April 25, 2018, includes the following:

Denial of payment for new admissions effective **June 21, 2018**.
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 **September 21, 2018**, 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 **March 21, 2018**, 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:

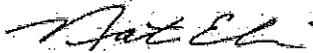
BFS Letters (06/30/11)

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

This request must be received by **April 11, 2018**. If your request for informal dispute resolution is received after **April 11, 2018**, 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

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

PRINTED: 03/29/2018
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 03/21/2018
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - MOSCOW VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 640 NORTH EISENHOWER STREET MOSCOW, ID 83843
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(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
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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 63 SNF/NF beds, and had a census of 54 on the dates of the survey. The following deficiencies were cited at the above facility during the annual fire/life safety code survey conducted on March 20 - 21, 2018. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Chapter 19, Existing Healthcare Occupancies, in accordance with 42 CFR 483.70, 42 CFR 483.80 and 42 CFR 483.65. The survey was conducted by: Linda Chaney Health Facility Surveyor Facility Fire Safety & 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 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked b) Who provided system test	K 353	K 353 SS=D 1. Sprinkler head replacements were ordered by Simplex Grinnell on 4/4/18 and will be scheduled for installment when Simplex Grinnell receives them. 2. All sprinkler heads will be audited to ensure that they are free of corrosion. 3. A preventive maintenance plan will be developed to inspect all sprinkler heads annually. 4. The Maintenance Director or designee will re-audit the sprinkler heads in six months. All audit findings will be reported to QA/CQI for further monitoring and modification. 5. Corrective action will be completed on or before May 30, 2018.	RECEIVED APR 17 2018 FACILITY STANDARDS 5/30/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Jamie Berg</i>	TITLE Administrator	(X6) DATE 4-11-18
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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 353	<p>Continued From page 1</p> <p>c) Water system supply source</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure fire suppression system pendants were maintained free of obstructions such as paint or corrosion. Failure to maintain fire sprinkler pendants free of obstructions could hinder system performance during a fire event. This deficient practice affected staff and visitors in the kitchen on the dates of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on March 21, 2018, from approximately 9:00 AM to 11:00 AM, observation of the kitchen dish room, revealed three (3) corroded sprinkler heads. When asked, the Director of Environmental Services stated the facility was not aware of the corroded heads.</p> <p>Actual NFPA standard:</p> <p>NFPA 25</p> <p>5.2.1 Sprinklers. 5.2.1.1* Sprinklers shall be inspected from the floor level annually. 5.2.1.1.1* Sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., upright, pendent, or sidewall). 5.2.1.1.2 Any sprinkler that shows signs of any of</p>	K 353			

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K 353	Continued From page 2 the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical damage (4) Loss of fluid in the glass bulb heat responsive element (5)*Loading (6) Painting unless painted by the sprinkler manufacturer	K 353		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide documentation of fire drills on all shifts quarterly. Failure to perform fire drills on each shift quarterly could result in confusion and hinder the safe evacuation of residents during a fire event. This deficient practice affected 54 residents, staff and visitors on the dates of the survey. Findings Include: During record review on March 20, 2018, from	K 712	K 712 SS=F 1. Fire drills will be completed and documented on all shifts quarterly. 2. All residents have the potential to be affected. 3. Fire drill monitoring will be added to the monthly Safety Committee Meeting agenda to ensure completion and documentation. 4. The Maintenance Director or designee will audit the fire drill reports monthly x 3. All audit findings will be reported to QA/CQI for further monitoring and modification. 5. Corrective action will be completed on or before May 30, 2018.	5/30/18

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K 712	Continued From page 3 approximately 8:30 AM to 4:30 PM, review of fire drill reports revealed the facility was missing fire drill documentation on second shift, third quarter 2017. When asked, the Director of Environmental Services stated he was new to his position and was unaware a fire drill had not been performed during that time frame. Actual NFPA Standard: NFPA 101 19.7.1.4* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. 19.7.1.6 Drills 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.	K 712			
K 911 SS=F	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567, Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the Essential Electrical System (EES) generator was equipped with a remote	K 911	K 911 SS=F 1. The facility is working diligently with Cummins Northwest to equip our generator with a remote manual stop switch. Due to the age of the generator it has been difficult to find parts. Cummins will complete an on-site evaluation of the generator on 4/11/18. The manual stop switch will be scheduled to be replaced the minute a viable option becomes available. 2. All residents have the potential to be affected. 3. A preventive maintenance plan will be developed to test the manual stop switch monthly. 4. The Maintenance Director or designee will audit the stop switch monthly x 3. All audit findings will be reported to QA/CQI for further monitoring and modification. 5. Corrective action will be completed on or before May 30, 2018.	5/30/18	

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K 911	Continued From page 4 manual stop switch. Failure to provide a remote stop switch prevents protection from the impact of adverse generator conditions. This deficient practice affected 54 residents, staff and visitors on the dates of the survey. Findings include: During the facility tour conducted on March 21, 2018, from approximately 9:00 AM to 11:00 AM, observation of the generator and the surrounding area revealed the facility did not provide a remote manual stop switch for the EES generator. When asked, the Director of Environmental Services stated the facility was not equipped with a remote stop switch for the generator. Actual NFPA standard: NFPA 110 5.6.5.6* All installations shall have a remote manual stop station of a type to prevent inadvertent or unintentional operation located outside the room housing the prime mover, where so installed, or elsewhere on the premises where the prime mover is located outside the building. 5.6.5.6.1 The remote manual stop station shall be labeled. NFPA 99 6.4.1.1.16.2 Safety indications and shutdowns shall be in accordance with Table 6.4.1.1.16.2. (SEE TABLE)	K 911			
K 916 SS=F	Electrical Systems - Essential Electric System CFR(s): NFPA 101 Electrical Systems - Essential Electric System	K 916			

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K 916	<p>Continued From page 5</p> <p>Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the EES (Essential Electrical System) was installed in accordance with NFPA 99. Failure to provide an alarm annunciator for the EES could hinder early notification of equipment failures, leaving the facility without emergency power during an outage. This deficient practice affected 54 residents, staff and visitors on the dates of the survey.</p> <p>Findings include:</p> <p>During the facility tour on March 21, 2018, from approximately 9:00 AM to 11:00 AM, observation of work stations throughout the facility did not reveal an alarm annunciator for the EES. When asked, the Director of Environmental Services stated he was not aware of an alarm panel, or other device which would indicate the facility was under auxiliary power (generator) during a power outage.</p> <p>Actual NFPA standard:</p> <p>NFPA 99 Chapter 6 Electrical Systems 6-4 Essential Electrical System Requirements -</p>	K 916	<p>K 916 SS=F</p> <ol style="list-style-type: none"> 1. The facility is working diligently with Cummins Northwest to equip our generator with an alarm annunciator. Due to the age of the generator it has been difficult to find parts. Cummins will complete an on-site evaluation of the generator on 4/11/18. The annunciator will be scheduled to be replaced the minute a viable option becomes available. 2. All residents have the potential to be affected. 3. A preventive maintenance plan will be developed to monitor the annunciator monthly. 4. The Maintenance Director or designee will audit the annunciator monthly x 3. All audit findings will be reported to QA/CQI for further monitoring and modification. 5. Corrective action will be completed on or before May 30, 2018. 	5/30/18

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K 916	Continued From page 6 Type 1. 6.4.1.1.17 Alarm Annunciator. A remote annunciator that is storage battery powered shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station (see 700.12 of NFPA 70, National Electrical Code). The annunciator shall be hard-wired to indicate alarm conditions of the emergency or auxiliary power source as follows: (1) Individual visual signals shall indicate the following: (a) When the emergency or auxiliary power source is operating to supply power to load (b) When the battery charger is malfunctioning (2) Individual visual signals plus a common audible signal to warn of an engine generator alarm condition shall indicate the following: (a) Low lubricating oil pressure (b) Low water temperature (below that required in 6.4.1.1.11) (c) Excessive water temperature (d) Low fuel when the main fuel storage tank contains less than a 4-hour operating supply (e) Overcrank (failed to start) (f) Overspeed	K 916			

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E 000	<p>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 63 SNF/NF beds, and had a census of 54 on the dates of the survey.</p> <p>The facility was found to be in substantial compliance during the initial Emergency Preparedness Survey conducted on March 20 - 21, 2018. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73.</p> <p>The survey was conducted by:</p> <p>Linda Chaney Health Facility Surveyor Facility Fire Safety & Construction</p>	E 000	<p style="text-align: center;">RECEIVED</p> <p style="text-align: center;">APR 17 2018</p> <p style="text-align: center;">FACILITY STANDARDS</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Jamie Berg</i>	TITLE <i>Administrator</i>	(X6) DATE <i>4/11/18</i>
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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.