



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

November 26, 2018

Brian Davidson, Administrator
Good Samaritan Society - Boise Village
3115 Sycamore Drive
Boise, ID 83703-4129

Provider #: 135085

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Mr. Davidson:

On **November 16, 2018**, a Facility Fire Safety and Construction survey was conducted at **Good Samaritan Society - Boise 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 one that comprises a pattern 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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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

Brian Davidson, Administrator
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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 **December 10, 2018**. Failure to submit an acceptable PoC by **December 10, 2018**, may result in the imposition of civil monetary penalties by **December 31, 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 **December 21, 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 **February 14, 2019**. A change in the seriousness of the deficiencies on **December 31, 2018**, may result in a change in the remedy.

Brian Davidson, Administrator
November 26, 2018
Page 3 of 4

The remedy, which will be recommended if substantial compliance has not been achieved by **December 21, 2018**, includes the following:

Denial of payment for new admissions effective **February 16, 2019**.
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 16, 2019**, 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 **November 16, 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:

Brian Davidson, Administrator
November 26, 2018
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<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:

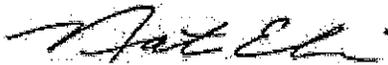
BFS Letters (06/30/11)

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

This request must be received by **December 10, 2018**. If your request for informal dispute resolution is received after **December 10, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135085	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE BLDG B. WING _____	(X3) DATE SURVEY COMPLETED 11/16/2018
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - BOISE VILLAG		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 SYCAMORE DRIVE BOISE, ID 83703		
(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(111) construction with multiple additions and renovations. The most recent addition was completed in 2002 on the West side. A complete fire alarm/smoke detection system was installed in 2001. The facility was originally built in 1957 and is fully sprinklered. Currently the facility is licensed for 127 SNF/NF beds and had a census of 82 on the date of the survey. The following deficiencies were cited during the annual fire/life safety survey conducted on November 15 and 16, 2018. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70. The Survey was conducted by: Sam Burbank Health Facility Surveyor Fire Life Safety & Construction	K 000	General Disclaimer 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 754 SS=D	Soiled Linen and Trash Containers CFR(s): NFPA 101 Soiled Linen and Trash Containers Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. Containers used solely for recycling are permitted to be excluded from the above requirements where each container is less than or equal to 96	K 754	K 754 – Soiled Linen and Trash Resident Specific The failure to ensure that highly combustible material was stored in accordance with NFPA 101 had the potential to affect 30 residents, staff and visitors in 2 of 8 smoke compartments on the date of the survey.	12/21/18

RECEIVED

DEC 10 2018

FACILITY STANDARDS

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

TITLE

(X6) DATE

Eric J. [Signature]

ADMINISTRATOR

12/5/18

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: 135085	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE BLDG B. WING _____	(X3) DATE SURVEY COMPLETED 11/16/2018
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K 754	<p>Continued From page 1</p> <p>gallons unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent. 18.7.5.7, 19.7.5.7</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, the facility failed to ensure that highly combustible material was stored in accordance with NFPA 101. Failure to provide protection of hazardous storage such as trash and soiled linens, could result in smoke and dangerous gases passing into corridors and affect the safe egress of residents during a fire. This deficient practice affected 30 residents, staff and visitors in 2 of 8 smoke compartments on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 11/15/18 from 10:30 AM - 12:00 PM, observation of the storage closet outside room 303, revealed the closet was constructed as a 1-hour construction, but only 1 of 2 doors to the closet was self-closing. Further observation revealed the space was used for the purpose of storing two (2) 50 gallon bins of soiled linens and one (1) 50 gallon bin of trash.</p> <p>Actual NFPA standard:</p> <p>NFPA 101</p> <p>19.7.5.7 Soiled Linen and Trash Receptacles. 19.7.5.7.1 Soiled linen or trash collection receptacles shall not exceed 32 gal (121 L) in capacity and shall meet all of the following requirements: (1) The average density of container capacity in a room or space shall not exceed 0.5 gal/ft2 (20.4</p>	K 754	<p>Other Residents</p> <p>The failure to ensure that highly combustible material is stored in accordance with NFPA 101 has the potential to affect all residents, staff and visitors.</p> <p>Facility System</p> <p>The storage closet outside room 303 now has both doors self-closing.</p> <p>Weekly inspections x4, bi-weekly inspections x2, and monthly inspections x4 will be completed by the Director of Environmental Services to ensure all storage closets housing highly combustible materials have self-closing doors and are working correctly.</p> <p>Quality Assurance and Monitoring</p> <p>The Director of Environmental Services will report any findings to the Quality Assurance and Performance Improvement (QAPI) meeting for further monitoring and plan modification if compliance is not met.</p> <p>Date of compliance</p> <p>December 21, 2018</p>	

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K 754	Continued From page 2 L/m2). (2) A capacity of 32 gal (121 L) shall not be exceeded within any 64 ft2 (6 m2) area. (3)*Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) shall be located in a room protected as a hazardous area when not attended. (4) Container size and density shall not be limited in hazardous areas.	K 754		
K 781 SS=D	Portable Space Heaters CFR(s): NFPA 101 Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that portable space heating devices were used in accordance with NFPA 101 and NFPA 70. Failure to monitor the maximum heat output of space heating devices used in nonsleeping staff areas and ensure they are used with listed and approved assemblies, has the potential to expose residents to the historical fire risks associated with these devices. This deficient practice affected staff and visitors of the Environmental Services office on the date of the survey. Findings include: During the facility tour conducted on 11/15/18 from 8:45 - 10:30 AM, observation of the Environmental Services office revealed a portable heater on the counter plugged into a multiple plug	K 781	<u>K 781 – Portable Space Heaters</u> <i>Resident Specific</i> The failure to ensure that portable space heating devices were used in accordance with NFPA 101 and NFPA 70 had the potential to affect staff and visitors in the Environmental Services Office on the date of the survey. <i>Other Residents</i> The failure to ensure that portable space heating devices are being used in accordance with NFPA 101 and NFPA 70 has the potential to affect all residents, staff and visitors. <i>Facility System</i> The Environmental Services Director has replaced the multi-plug adapter with a multi-plug outlet and now the portable heater is directly plugged into the wall outlet. The portable heater is now tagged showing the maximum heat output. Weekly inspections x4, bi-weekly inspections x2, and monthly inspections x4 will be completed by the Director of Environmental Services to ensure all portable	12/21/18

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K 781	Continued From page 3 adapter (MPA), Further observation did not establish any tag or identification as to the maximum heat output of the heater. When asked about the heater and lack of information of the temperature maximum range, the Environmental Services Director stated this heater was assigned to the office, but was not aware it had not been identified as to the maximum heat output. Actual NFPA standard: 19.7.8 Portable Space-Heating Devices. Portable spaceheating devices shall be prohibited in all health care occupancies, unless both of the following criteria are met: (1) Such devices are used only in nonsleeping staff and employee areas. (2) The heating elements of such devices do not exceed 212°F (100°C).	K 781	space heaters are directly plugged into the wall outlet and are tagged showing the maximum heat output. Any issues found will be immediately corrected. Quality Assurance and Monitoring The Director of Environmental Services will report any findings to the Quality Assurance and Performance Improvement (QAPI) meeting for further monitoring and plan modification if compliance is not met. Date of compliance	
K 923 SS=E	Gas Equipment - Cylinder and Container Storage CFR(s): NFPA 101 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	K 923	December 21, 2018 <u>K 923 – Gas Equipment – Cylinder and Container Storage</u> Resident Specific The failure to segregate full oxygen cylinders from empty oxygen cylinders had the potential to affect Syringa I residents in need of supplemental oxygen. Other Residents The failure to segregate full oxygen cylinders from empty	12/21/18

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K 923	<p>Continued From page 4</p> <p>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."</p> <p>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.</p> <p>11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, the facility failed to ensure pressurized medical gas cylinders were maintained in accordance with NFPA 99. Failure to segregate and identify full and empty pressurized oxygen cylinders has the potential to inadvertently use the incorrect cylinder during an emergency requiring supplemental oxygen. This deficient practice affected those residents requiring supplemental oxygen treatment, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 11/15/18 from 1:00 - 3:30 PM, observation of the oxygen storage room in Syringa 1 corridor by room 210, revealed three (3) "E" cylinders identified as "full" by the Environmental Services Director, stored on the side marked "Empty".</p>	K 923	<p>oxygen cylinders has the potential to affect all residents in need of supplemental oxygen.</p> <p>Facility System</p> <p>The Environmental Services Director has setup a system to segregate full oxygen cylinders from empty oxygen cylinders. The staff will mark the empty cylinders by placing a tag over the top stating, "Cylinder Empty, Do Not Use" and then keep these cylinders separately stored from the full cylinders.</p> <p>A memo has been placed at each oxygen storage area to remind staff to segregate full and empty oxygen cylinders.</p> <p>Weekly inspections x4, bi-weekly inspections x2, and monthly inspections x4 will be completed by the Director of Environmental Services to ensure the full oxygen cylinders are separately stored from the empty oxygen cylinders.</p> <p>Quality Assurance and Monitoring</p> <p>The Director of Environmental Services will report any findings to the Quality Assurance and Performance Improvement (QAPI) meeting for further monitoring</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135085	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE BLDG B. WING _____	(X3) DATE SURVEY COMPLETED 11/16/2018
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K 923	Continued From page 5 Actual NFPA standard: NFPA 99 11.6.5 Special Precautions - Storage of Cylinders and Containers. 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. 11.6.5.2 If empty and full cylinders are stored within the same enclosure, empty cylinders shall be segregated from full cylinders. 11.6.5.3 Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed in a rapid manner.	K 923	and plan modification if compliance is not met. <i>Date of compliance</i> December 21, 2018	



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Provider #: 135085

RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER

Dear Mr. Davidson:

On **November 16, 2018**, an Emergency Preparedness survey was conducted at **Good Samaritan Society - Boise Village** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with 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 one that comprises a pattern 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. 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 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.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **December 10, 2018**. Failure to submit an acceptable PoC by **December 10, 2018**, may result in the imposition of civil monetary penalties by **December 31, 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 **December 21, 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 . A change in the seriousness of the deficiencies on **January 10, 2019**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **December 21, 2018**, includes the following:

Denial of payment for new admissions effective **February 16, 2019**.
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 16, 2019**, 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 **November 16, 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>

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 **December 10, 2018**. If your request for informal dispute resolution is received after **December 10, 2018**, the request will not be granted. An incomplete

Brian Davidson, Administrator
November 26, 2018
Page 4 of 4

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,

A handwritten signature in black ink, appearing to read "Nate Elkins". The signature is fluid and cursive, with a prominent initial "N" and a long, sweeping underline.

Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosures

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

Printed: 11/20/2018
FORM APPROVED
OMB NO. 0938-0391

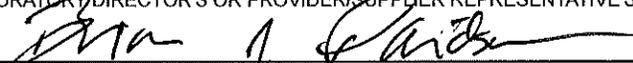
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135085	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/16/2018
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - BOISE VILLAG	STREET ADDRESS, CITY, STATE, ZIP CODE 3115 SYCAMORE DRIVE BOISE, ID 83703
------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------

(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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E 000	<p>Initial Comments</p> <p>The facility is a single story, type V(111) construction with multiple additions and renovations. The most recent addition was completed in 2002 on the West side. A complete fire alarm/smoke detection system was installed in 2001. The facility was originally built in 1957 and is fully sprinklered. The facility is equipped with an on-site Emergency Electrical System (EES) generator and is located in a municipal fire district with both county and state EMS support services available. Currently the facility is licensed for 127 SNF/NF beds and had a census of 82 on the date of the survey.</p> <p>The following deficiencies were cited during the initial Emergency Preparedness Survey conducted on November 15 and 16, 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>Sam Burbank Health Facility Surveyor Fire Life Safety & Construction</p>	E 000	<p><u>General Disclaimer</u></p> <p>Preparation and Execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law. For the purposes of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations manual.</p>	
E 039 SS=D	<p>EP Testing Requirements CFR(s): 483.73(d)(2)</p> <p>(2) Testing. The [facility, except for LTC facilities, RNHCs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCs and OPOs] must do all of the following:</p> <p>*[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency</p>	E 039	<p><u>E 039 EP Testing Requirements</u></p> <p><u>Resident Specific</u></p> <p>The failure to complete two (2) full scale drills for the activation of the Emergency Plan (EP) had the potential to affect 82 residents, staff and visitors on the date of the survey.</p>	12/21/18

RECEIVED
DEC 10 2018
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE ADMINISTRATOR	(X6) DATE 12/5/18
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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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135085	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/16/2018
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E 039	<p>Continued From page 1 procedures. The LTC facility must do all of the following:]</p> <p>(i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event.</p> <p>(ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.</p> <p>*[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p>	E 039	<p>Other Residents</p> <p>The failure to complete two (2) full scale drills for the activation of the Emergency Plan (EOP) has the potential to affect all residents, staff and visitors.</p> <p>Facility System</p> <p>The facility will complete two (2) full scale drills for the activation of the Emergency Plan at least annually, with one being Community-based or individual, facility based, and the other as a table-top exercise that includes a group discussion.</p> <p>The Environmental Services Director and select members from the facility's safety committee will analyze the facility's response and maintain documents of all drills, tabletop exercises, and emergency events, and revise the facility's emergency plan, as needed.</p> <p>Quality Assurance and Monitoring</p> <p>The Director of Environmental Services will report any findings to the Quality Assurance and Performance Improvement (QAPI) meeting for further monitoring and plan modification if</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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E 039	<p>Continued From page 2</p> <p>(ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to complete two (2) full scale drills as required. Failure to complete two full-scale exercises for the activation of the Emergency plan (EOP), has the potential to hinder staff performance during an actual emergency. This deficient practice affected 82 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During review of the facility EOP testing records conducted on 11/15/18 from 1:00 - 3:00 PM, records provided established full documentation of a tabletop exercise, but lacked substantial, complete documentation for a full-scale facility-based exercise, as the documentation lacked the scenario timeline and after-action reporting on the effectiveness of the EOP.</p> <p>Reference:</p> <p>42 CFR 483.73 (d) (1)</p>	E 039	<p>compliance is not met.</p> <p><i>Date of compliance</i></p> <p>December 21, 2018</p>		