



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

BRAD LITTLE- Governor  
DAVE JEPPESEN- Director

TAMARA PRISOCK—ADMINISTRATOR  
LICENSING & CERTIFICATION  
DEBBY RANSOM, R.N., R.H.I.T – Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P. O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: (208) 334-6626  
FAX: (208) 364-1888  
E-mail: [fsb@dhw.idaho.gov](mailto:fsb@dhw.idaho.gov)

February 6, 2019

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

Provider #: 135067

Dear Ms. Berg:

**Congratulations** to both you and your staff on your deficiency-free survey. In today's world with numerous regulations, it is indeed impressive to see a facility functioning as a team at this level.

Continuing to meet the needs of your residents – while recognizing and meeting the administrative needs of your business – is a daily commitment to quality ongoing assessment, care planning and consistent provision of services to each and every client. The greater challenge, of course, is to be able to work as a team to provide this high level of caring and service day after day, week after week, year after year.

Again, **Congratulations** to you and your staff for a job well done, and I challenge you to keep this same high standard in the coming year.

Sincerely,

DEBRA RANSOM, R.N., R.H.I.T.  
Bureau Chief



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February 6, 2019

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

Provider #: 135067

Dear Ms. Berg:

On **January 17, 2019**, 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 requirements for nursing homes.

Enclosed is a Statement of Deficiencies and Plan of Correction, State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **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 state tag 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.

After each deficiency has been answered and dated, the administrator should sign the 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 **February 15, 2019**.

The components of a Plan of Correction as required 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).

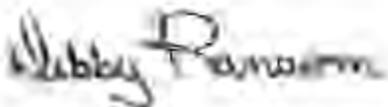
If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining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

If you believe these deficiencies have been corrected, you may contact Debby Ransom, RN, RHIT, Bureau Chief, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 5; 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.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Debby Ransom, RN, RHIT, Bureau Chief at (208) 334-6626, option 5.

Sincerely,



Debby Ransom, RN, RHIT, Chief  
Bureau of Facility Standards

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

PRINTED: 02/22/2019  
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>01/17/2019</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	<p><b>INITIAL COMMENTS</b></p> <p>A recertification and complaint survey was conducted January 14, 2019 through January 17, 2019 at Good Samaritan Society - Moscow Village. The facility was found to be in substantial compliance with 42 CFR Part 483 Requirements for Long Term Care Facilities.</p> <p>The surveyors conducting the survey were:</p> <p>Jenny Walker, RN, Team Leader Marcia Mital, RN Sharon Dunn, RD</p>	F 000			

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

TITLE

(X6) DATE

Electronically Signed

02/06/2019

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.

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>01/17/2019</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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(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><b>INITIAL COMMENTS</b></p> <p>The following deficiency was cited during the State licensure survey conducted at the facility from January 14, 2019 to January 17, 2019.</p> <p>The surveyors conducting the survey were:</p> <p>Jenny Walker, RN, Team Leader Marcia Mital, RN Sharon Dunn, RD</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 attendance records and staff interview, it was determined the facility failed to ensure a representative from each required department 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 1/17/19 at 5:00 PM, the Administrator stated the facility held Quality Assurance Performance Improvement meetings monthly and infection control was a component of those meetings.</p> <p>On 1/17/19 at 5:30 PM, the Administrator provided attendance records, dated 7/10/18, 8/14/18, 9/17/18, 10/8/18, 11/6/18,12/18/18, and</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 7305 of the State Operations manual.</p> <p>1. N/A - no residents were identified.</p>	2/15/19

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Electronically Signed	TITLE	(X6) DATE  02/06/19
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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>01/17/2019</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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(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 664	Continued From page 1  1/8/19, which did not include documentation the Dietary Manager or a dietary representative attended these meetings. The Administrator was unable to provide additional information a dietary representative attended the Infection Control meetings listed above.	C 664	<p>2. All residents have the potential to be affected by the Dietary Manager's lack of participation. The Dietary Manager will be added to the Infection Control Meeting participant list. If the Dietary Manager is unavailable, a designee will attend quarterly in her place.</p> <p>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.</p> <p>4. The QAPI Coordinator or designee will audit the QAPI/Infection Control Meeting/minutes to ensure the Dietary Manager attends quarterly x 3 quarters. All findings will be reported to the QAPI Committee for further monitoring and modification.</p>	



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June 5, 2019

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

Provider #: 135067

Dear Ms. Berg:

On **January 14, 2019** through **January 17, 2019**, an unannounced on-site complaint survey was conducted at Good Samaritan Society - Moscow Village. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00007832**

**ALLEGATION #1:**

The facility failed to ensure residents were appropriately groomed.

**FINDINGS #1:**

Observations were conducted throughout the facility, in resident rooms and common areas. There were no odors that would indicate a lack of care. Nine residents were interviewed during the survey, six residents attended the group meeting and were questioned about their care, missing items, call lights, and other topics. No concerns were identified. Four family members and several staff were interviewed throughout the four-day survey, with no concerns identified related to a lack of hygiene or personal care for the residents.

During observations throughout the survey, the residents were clean and groomed and were being assisted with dressing and/or changing of their clothing if soiled. Fourteen residents were reviewed and no concerns were identified related to a lack of care being provided by the facility staff.

The observations and interviews with residents, family members and staff confirmed the residents were assisted with their hygiene and grooming as needed.

Due to investigative findings, the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The facility failed to ensure residents were kept free of preventable falls.

FINDINGS #2:

Observations were conducted throughout the facility and throughout the four-day survey. Nine residents were interviewed, six residents attended the group meeting and no concern with safety and or accidents were identified. Four family members and several staff members were interviewed during the survey regarding resident care & specifically the concerns noted in the complaint allegation. Additionally, four residents who had experienced falls were reviewed and there were no safety concerns identified and the facility had processes in place to promote resident safety.

The investigation findings showed the facility implemented and updated interventions related to resident falls and safety measures and policies were in place to keep residents safe. One resident's falls were reviewed, and interventions were added and changed in attempt to prevent falls for the resident. The resident received Physical Therapy, and therapy notes indicated the resident was ambulating during his stay at the facility.

Due to investigative findings, the allegation was unsubstantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The facility failed to ensure call bells were available to residents.

FINDINGS #3:

Call light observations were conducted throughout the four-day survey in resident rooms and common areas. Calls lights were monitored without concerns identified. Family, staff and 14 resident interviews were conducted with no concerns related to call lights not functioning or not being accessible to residents. A group of residents were interviewed about a variety of topics including call lights and the residents denied concerns with accessibility or timeliness of call light responses.

Due to investigative findings, the allegation was unsubstantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The facility failed to ensure residents were provided with meals.

FINDINGS #4:

Meal observations were conducted throughout the survey both in dining rooms and resident rooms. Residents, families and staff were interviewed. Residents were offered meals, and if they did not want their meals at that time, the staff held it for later or got them food when they requested it. The residents and family interviews stated they were always able to get snacks when they requested them, and there were no concerns of residents not getting enough to eat.

Due to investigative findings, the allegation was not substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

The facility failed to ensure residents were properly positioned.

FINDINGS #5:

The investigation included observations and interviews throughout the four-day survey and no concerns with resident positioning were identified. Staff interacted with the residents and assisted them as needed. No observations were made of poorly positioned dependent residents whether in their beds or their chairs. Interviews with residents and family members stated staff assisted residents with positioning as needed.

Due to investigative findings, the allegation was unsubstantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

The facility failed to respond to a complaint related to a resident's lost personal items.

FINDINGS #6:

Review of one resident's record had a comment on the back of his inventory sheet by a family member about a missing personal item. There was no complaint, grievance, or report of the missing item prior to that time. The facility did have the item turned into the social service office for several months, but did not know who had lost it. Interviews with residents and family members stated they did not have concerns with missing items. The Administrator stated when items were found they were taken to social service office and they attempted to find out who the items belonged to.

Due to investigative findings, the allegation a resident had a missing personal item was substantiated. However the facility was not cited with deficient practice because the investigation did not substantiate current deficient practice.

CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

ALLEGATION #7:

The facility failed to ensure nursing staff appropriately managed medications that fell to the floor.

FINDINGS #7:

During the investigation, there were no observations of residents' medication being dropped on the floor and then administered to the resident. Four medication pass observations were made with with four different nurses on different halls and different shifts. There were no observations of medications being given after being dropped. Interviews with the four nurses observed for medication pass stated they destroyed medications if they were dropped and got new medications for the residents. Interviews with residents stated they had never been given medications that had been dropped on the floor.

Due to investigative findings, the allegation was unsubstantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Jamie Berg, Administrator  
June 5, 2019  
Page 5 of 5

ALLEGATION #8:

The facility failed to ensure residents received adequate oral care.

FINDINGS #8:

During the investigation, there were no observations of residents with poor oral care. One resident's record documented he had his own teeth, was assisted with oral care daily and received dental evaluations approximately every three months. Interviews with residents and family members stated staff assisted residents with oral care. The facility has a program where a dental assistant comes to the facility every evening and brushes and flosses the residents' teeth.

Due to investigative findings, the allegation was unsubstantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,



Belinda Day, RN, Supervisor  
Long Term Care Program

BD/lj



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June 19, 2019

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

Provider #: 135067

Dear Ms. Berg:

On **January 17, 2019**, an unannounced on-site complaint survey was conducted at Good Samaritan Society - Moscow Village. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00007935**

ALLEGATION #1:

The facility failed to ensure resident rights to smoke were addressed.

FINDINGS #1:

Three surveyors conducted an unannounced onsite recertification survey and complaint investigation at the facility from January 14, 2019 through January 17, 2019. Observations were conducted throughout the facility, interviews were conducted with residents, family members, and staff members; and resident records and facility policies were also reviewed.

The facility's policy titled "Smoking Process" documented if a resident's Tobacco Use Assessment indicated a need for assistance with smoking, it would be the resident's responsibility to have assistance provided to them. The facility's current Smoking Process documented effective 2/22/18, the facility became a smoke-free campus. The policy stated existing residents who

smoked were grandfathered in. The policy also stated that if the resident's Tobacco Use Assessment indicated a need for assistance with smoking it would be the resident's responsibility to have assistance provided to them.

One resident's record included a Tobacco Use Assessment which documented the resident was assessed as being capable of smoking independently. Review of the next "Tobacco Use Assessment" for the resident documented after readmission to the facility following a hospitalization, he was assessed as needing supervision while smoking.

Review of the Admission Agreement signed by the resident documented, he signed and received the "Smoke-Free Policy" prior to admission to the facility.

During an interview with the facility's Administrator, she stated the resident could smoke while they were in the facility. She stated when the resident was assessed as needing supervision with smoking, she had staff supervise the resident's smoking up until the time of discharge. She stated they did provide the resident with supervision to smoke and developed a schedule of smoking times with staff assigned to supervise the resident's smoking up until they were discharged.

In an interview with the Licensed Social Worker, she stated when the resident was assessed as requiring supervision with smoking, a smoking schedule was put in place and the resident did not have to go all day without smoking.

#### CONCLUSIONS:

Based on investigative findings, the allegation could not be substantiated, and no deficient practice was identified.

#### ALLEGATION #2:

The facility failed to provide adequate notice prior to discharging residents from the facility.

#### FINDINGS #2:

Review of a resident's "Durable Power of Attorney" documented the resident agreed to have a family member act as his Durable Power of Attorney for finances only.

In an interview with the facility's Administrator and Licensed Social Worker, they verified the resident's family member was the Durable Power of Attorney for finance only. They also stated the resident could make his own decisions. The Administrator stated a 30-day notice was not issued because the resident chose to move. Therefore, the 30 day notice was not required.

Review of Social Service Progress Notes signed by the Licensed Social Worker documented the following:

The resident was currently competent to make his own decisions and she would continue to help facilitate discharge.

The Licensed Social Worker spoke with the resident's family member multiple times. She stated the resident and the family member toured the facility and expressed satisfaction after touring the new facility. She also wrote she educated the family member his power of attorney was only activated if the resident was deemed incompetent.

During the survey, the ombudsman was called. She stated she spoke with the resident and it was his decision to move.

#### CONCLUSIONS:

Based on investigative findings, the allegation was unable to be substantiated, and no deficient practice was identified.

#### ALLEGATION #3:

The facility failed to ensure residents' clothing was appropriately returned.

#### FINDINGS #3:

During the investigation, 15 residents and four family members were interviewed and there were no complaints related to missing items or the facility failing to return their personal belongings.

In one resident's record, a social service progress note, documented she spoke with the resident's family member after the resident was discharged and asked when he could pick up and transfer the resident's personal items. She wrote the family member stated he did not have time.

In an interview with the Licensed Social Worker, she stated the resident had Medicaid transport pick up some of the belongings, the social worker transported some of the items, and the family member was to transport the remaining items. She stated when the family member did not come and get the remaining items the Director of Nursing transported the remaining items to the new facility herself. She stated it a few days between the discharge and when the items left behind were transported.

In an interview with the Director of Nursing, she confirmed all the resident's items had been boxed up and she took everything that was left by the resident to the new facility in a couple of

Jamie Berg, Administrator  
June 19, 2019  
Page 4

days after the transfer of the resident.

CONCLUSIONS:

Based on investigative findings, the allegation could not be substantiated and no deficient practice was identified.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,



BELINDA DAY, RN, Supervisor  
Long Term Care Program

BD/slj