January 31, 2020

Craig Perez, Administrator
Good Samaritan Society - Idaho Falls Village
840 East Elva Street
Idaho Falls, ID 83401-2899

Provider #: 135092

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Mr. Perez:

On January 23, 2020, a Facility Fire Safety and Construction survey was conducted at Good Samaritan Society - Idaho Falls 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 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 **February 13, 2020.** Failure to submit an acceptable PoC by **February 13, 2020,** may result in the imposition of civil monetary penalties by **March 6, 2020.**

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 **February 27, 2020,** (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 22, 2020.** A change in the seriousness of the deficiencies on **March 8, 2020,** may result in a change in the remedy.
The remedy, which will be recommended if substantial compliance has not been achieved by **February 27, 2020**, includes the following:

**Denial of payment for new admissions effective April 23, 2020.**

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 **July 23, 2020**, 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 **January 23, 2020**, 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:

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 **February 13, 2020**. If your request for informal dispute resolution is received after **February 13, 2020**, 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
The facility is a single story, Type V (111) structure, originally constructed in 1964. The facility is fully sprinklered with an interconnected fire alarm/smoke detection system. The partial basement houses mechanical equipment and the on-site, diesel-fired Emergency Power Supply System (EPSS) generator. The facility is currently licensed for 113 SNF/NF beds with a census of 47 on the date of the survey.

The following deficiencies were cited during the annual fire/life safety survey conducted on January 23, 2020. 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
Facility Fire Safety and Construction

K 321 Hazardous Areas - Enclosure

K321

It was determined that the doors to rooms 214, 215, and 319 would not self-close at the time of inspection. The requirement to self-close was required due to the fact that these rooms contained storage items. The facility environmental service director will correct the deficiency by activating the self-closing hinges which the doors were already equipped with.
<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
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<tbody>
<tr>
<td>K 321</td>
<td>Continued From page 1</td>
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<td></td>
<td>hazardous areas that are deficient in REMARKS, 19.3.2.1, 19.3.5.9</td>
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<td>Area Automatic Sprinkler Separation N/A</td>
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<td>a. Boiler and Fuel-Fired Heater Rooms</td>
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<td>b. Laundries (larger than 100 square feet)</td>
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<td>c. Repair, Maintenance, and Paint Shops</td>
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<td>d. Soiled Linen Rooms (exceeding 64 gallons)</td>
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<td>e. Trash Collection Rooms (exceeding 64 gallons)</td>
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<td>f. Combustible Storage Rooms/Spaces (over 50 square feet)</td>
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<td>g. Laboratories (if classified as Severe Hazard - see K322)</td>
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<td>This REQUIREMENT is not met as evidenced by:</td>
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<td>Based on observation, operational testing and interview, the facility failed to ensure rooms converted to storage areas, would self-close in accordance with NFPA 101. Failure to provide self-closing doors on areas converted to storage, has the potential to allow fire, smoke and dangerous gases to pass into corridors and affect the safe egress of residents. This deficient practice affected staff on the date of the survey.</td>
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<td>Findings include:</td>
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<td>During the facility tour conducted on 1/23/20 from 11:00 AM - 2:30 PM, observation of rooms 214, 215 and 319, revealed these areas held assorted storage such as resident belongings, clothing stored in cardboard boxes, foam mattresses and mechanical equipment. Further observation of the doors entering rooms 215 and 319 from the corridor, revealed these doors were equipped with self-closing hinges, however operational testing of all three room’s corridor doors, revealed they would not self-close.</td>
<td></td>
<td>After the corrective action, no additional residents, staff, or visitors should be affected by the deficiency.</td>
<td>2/27/2020</td>
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</table>
K 321 Continued From page 2

Actual NFPA standard:

3.3.21.4* Hazardous Area. An area of a structure or building that poses a degree of hazard greater than that normal to the general occupancy of the building or structure.

19.3.2 Protection from Hazards.
19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.7.1.
19.3.2.1.1 An automatic extinguishing system, where used in hazardous areas, shall be permitted to be in accordance with 19.3.5.9.
19.3.2.1.2* Where the sprinkler option of 19.3.2.1 is used, the areas shall be separated from other spaces by smoke partitions in accordance with Section 8.4.
19.3.2.1.3 The doors shall be self-closing or automatic-closing.

K 324 Cooking Facilities

Cooking Facilities

Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless:
* residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2
* cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or
* cooking facilities in smoke compartments with

K 324 K324

It was determined that one of the wet chemical (ANSUL) fire suppression system pendants in the kitchen was missing a protective cap. This was immediately corrected during the inspection by the facility administrator - who re-installed the cap, which was hanging by a retaining strap. It was also determined that one pair of hood filters had a half-inch gap in the center between the two filters. The facility environmental service director or designee will order and install replacement filters - verifying that the gap has been eliminated.

After the corrective action, no additional residents, staff, or visitors should be affected by the deficiency.
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

#### PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:

135092

#### MULTIPLE CONSTRUCTION

A. BUILDING 02 - ENTIRE STRUCTURE

B. WING __________

#### DATE SURVEY COMPLETED

01/23/2020

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#### NAME OF PROVIDER OR SUPPLIER

GOOD SAMARITAN SOCIETY - IDAHO FALLS

#### STREET ADDRESS, CITY, STATE, ZIP CODE

840 EAST ELVA STREET

IDAHO FALLS, ID 83401

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#### SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>K 324</th>
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</table>

30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2

This REQUIREMENT is not met as evidenced by:

Based on observation, the facility failed to ensure kitchen hood systems installed in accordance with UL 300 were maintained in accordance with NFPA 96 and NFPA 17A. Failure to ensure fire suppression system protective caps remain in place and hood filters are free of gaps, has the potential to hinder system response and increase the risk of grease fires, by allowing grease laden vapors to bypass the filtration system. This deficient practice affected staff on the date of the survey.

Findings include:

During the facility tour conducted on 1/23/20 from 11:00 AM - 2:30 PM, observation of the main kitchen UL 300 hood system, revealed a protective cap was missing from 1 of 3 wet chemical (ANSUL) fire suppression system pendants on the west side of the hood. Further observation of the east side of the hood revealed an approximately half-inch gap between one pair of the filters that extended from the bottom to the top of the filter.

Actual NFPA standard:

The facility environmental service director provided in-service training to the dietary department staff on proper installation of the identified devices. Training was also provided on proper cleaning of hood filters to avoid damage or distortions. The dietary staff will perform weekly checks and maintenance as needed. The facility environmental service director will perform quarterly checks to ensure compliance.

The environmental service director or designee will report the results of the quarterly checks to the facility safety committee – which reports to the QAPI committee.

The corrective actions will be completed by 2/27/2020
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<tr>
<th>K 324</th>
<th>Continued From page 4</th>
<th>K 325</th>
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<tbody>
<tr>
<td>NFPA 96</td>
<td>6.2.3 Grease Filters.</td>
<td>K 325</td>
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<td>NFPA 17A</td>
<td>6.2.3.3 Grease filters shall be arranged so that all</td>
<td>K325</td>
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<td>exhaust air passes through the grease filters.</td>
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<td>NFPA 17A</td>
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<td>4.3.1.5 All discharge nozzles shall be provided</td>
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<td>with caps or other suitable devices to prevent the</td>
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<td>entrance of grease vapors, moisture, or other</td>
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<td>foreign materials into the piping</td>
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<td>Alcohol Based Hand Rub Dispenser (ABHR)</td>
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<td>Aluminum Based Hand Rub Dispenser (ABHR)</td>
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<td>CFR(s): NFPA 101</td>
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<td>K 325</td>
<td>A review of the center's records found</td>
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<td>ABHR inspection and testing records did not</td>
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<td>demonstrate the facility was completing</td>
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<td>required testing and inspection of ABHR</td>
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<td>dispensers during the refilling process.</td>
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<td>The facility will correct this deficiency by</td>
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<td>properly testing and documenting the</td>
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<td>operation of ABHR dispensers in</td>
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<td>accordance with the manufacturer's care</td>
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<td>and use instructions each time a new refill</td>
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<td>is installed. The facility will also take the</td>
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<td>extra step of performing a one-time test on</td>
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<td>all dispensers by the compliance date –</td>
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<td>even if a refill is not required.</td>
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After the corrective action, no additional residents, staff, or visitors should be affected by the deficiency.

The facility environmental service director will provide training to all housekeeping staff on the proper method of testing and documenting the operation of ABHR dispensers in accordance with the manufacturer's care and use instructions. The environmental service director will perform quarterly checks to ensure compliance.
K 325 Continued From page 5
482, 483, and 485
This REQUIREMENT is not met as evidenced by:
Based on record review, observation and interview, the facility failed to ensure Alcohol-Based Hand Rub (ABHR) dispensers were maintained in accordance with NFPA 101. Failure to test and document operation of ABHR dispensers under manufacturer's recommendations and in accordance with the standard, has the potential of increasing the risk of fires from flammable liquids. This deficient practice affected 47 residents and staff on the date of the survey.

Findings include:

1) During the review of facility maintenance and inspection records conducted on 1/23/20 from 8:45 - 11:00 AM, ABHR inspection and testing records did not demonstrate the facility was completing required testing and inspection of ABHR dispensers during the refilling process. Review of the documentation established two (2) procedures being completed: "Dispenser in good working condition" and "Dispensing proper amount".

2) During the facility tour conducted on 1/23/20 from 11:00 AM - 2:30 PM, observation of installed ABHR dispensers revealed both manual and automatic dispensers installed throughout the facility.

Actual NFPA standard:

19.3.2.6* Alcohol-Based Hand-Rub Dispensers. Alcohol-based hand-rub dispensers shall be protected in accordance with 8.7.3.1, unless all of the following conditions are met:

The environmental service director or designee will report the results of the quarterly checks to the facility safety committee – which reports to the QAPI committee.

The corrective action will be completed by: 2/27/2020
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

**(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:** 135092

**(X2) MULTIPLE CONSTRUCTION**
- **A. BUILDING 02 - ENTIRE STRUCTURE**
- **B. WING ______________**

**DATE SURVEY COMPLETED:** 01/23/2020

**NAME OF PROVIDER OR SUPPLIER:** GOOD SAMARITAN SOCIETY - IDAHO FALLS

**STREET ADDRESS, CITY, STATE, ZIP CODE:** 840 EAST ELVA STREET, IDAHO FALLS, ID 83401

<table>
<thead>
<tr>
<th>ID</th>
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<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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</thead>
</table>
| K 325 | Continued From page 6 | *(1) Where dispensers are installed in a corridor, the corridor shall have a minimum width of 6 ft (1830 mm).  
(2) The maximum individual dispenser fluid capacity shall be as follows:  
(a) 0.32 gal (1.2 L) for dispensers in rooms, corridors, and areas open to corridors  
(b) 0.53 gal (2.0 L) for dispensers in suites of rooms  
(3) Where aerosol containers are used, the maximum capacity of the aerosol dispenser shall be 18 oz. (0.51 kg) and shall be limited to Level 1 aerosols as defined in NFPA 30 B, Code for the Manufacture and Storage of Aerosol Products.  
(4) Dispensers shall be separated from each other by horizontal spacing of not less than 48 in. (1220 mm).  
(5) Not more than an aggregate 10 gal (37.8 L) of alcohol based hand-rub solution or 1135 oz (32.2 kg) of Level 1 aerosols, or a combination of liquids and Level 1 aerosols not exceeding, in total, the equivalent of 10 gal (37.8 L) or 1135 oz (32.2 kg), shall be in use outside of a storage cabinet in a single smoke compartment, except as otherwise provided in 19.3.2.6(6).  
(6) One dispenser complying with 19.3.2.6 (2) or (3) per room and located in that room shall not be included in the aggregated quantity addressed in 19.3.2.6(5).  
(7) Storage of quantities greater than 5 gal (18.9 L) in a single smoke compartment shall meet the requirements of NFPA 30, Flammable and Combustible Liquids Code.  
(8) Dispensers shall not be installed in the following locations:  
(a) Above an ignition source within a 1 in. (25 mm) horizontal distance from each side of the ignition source  
(b) To the side of an ignition source within a 1 in.** | K 325 | | |

**COMPLETION DATE:** MEQK21

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**FORM CMS-1567(02-99) Previous Versions Obsolete**

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**If continuation sheet Page 7 of 21**
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
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<tbody>
<tr>
<td>135092</td>
<td>A. BUILDING 02 - ENTIRE STRUCTURE</td>
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<td>B. WING ____________________</td>
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**NAME OF PROVIDER OR SUPPLIER**

GOOD SAMARITAN SOCIETY - IDAHO FALLS

**STREET ADDRESS, CITY, STATE, ZIP CODE**

840 EAST ELVA STREET
IDAHO FALLS, ID 83401

**DATE SURVEY COMPLETED**

01/23/2020

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**SUMMARY STATEMENT OF DEFICIENCIES**

Each deficiency must be preceded by full regulatory or LSC identifying information.

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<td>(25mm) horizontal distance from the ignition source</td>
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<td>(c) Beneath an ignition source within a 1 in. (25 mm) vertical distance from the ignition source</td>
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<td>(9) Dispensers installed directly over carpeted floors shall be permitted only in sprinklered smoke compartments.</td>
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<td>(10) The alcohol-based hand-rub solution shall not exceed 95 percent alcohol content by volume.</td>
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<td>(11) Operation of the dispenser shall comply with the following criteria:</td>
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<td>(a) The dispenser shall not release its contents except when the dispenser is activated, either manually or automatically by touch-free activation.</td>
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<td>(b) Any activation of the dispenser shall occur only when an object is placed within 4 in. (100 mm) of the sensing device.</td>
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<td>(c) An object placed within the activation zone and left in place shall not cause more than one activation.</td>
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<td>(d) The dispenser shall not dispense more solution than the amount required for hand hygiene consistent with label instructions.</td>
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<td>(e) The dispenser shall be designed, constructed, and operated in a manner that ensures that accidental or malicious activation of the dispensing device is minimized.</td>
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<td>(f) The dispenser shall be tested in accordance with the manufacturer's care and use instructions each time a new refill is installed.</td>
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<tr>
<td>K325</td>
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<td>K325 It was found that the facility was not performing monthly control valve inspections of the fire suppression system in accordance with NFPA 25. The facility environmental service director will perform an immediate inspection and then schedule monthly inspections into the TELS system.</td>
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**K353 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,
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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<tr>
<td>K353</td>
<td>Continued From page 8</td>
<td>maintenance, inspection and testing are maintained in a secure location and readily available.</td>
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<td>K353</td>
<td>After the corrective action, no additional residents, staff, or visitors should be affected by the deficiency.</td>
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<tr>
<td>a) Date sprinkler system last checked</td>
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<td>b) Who provided system test</td>
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<td>c) Water system supply source</td>
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<td>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.</td>
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<tr>
<td>9.7.5, 9.7.7, 9.7.8, and NFPA 25</td>
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<td>This REQUIREMENT is not met as evidenced by:</td>
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<td>Based on record review and interview, the facility failed to ensure fire suppression systems were maintained in accordance with NFPA 25. Failure to ensure fire suppression systems were maintained free of obstructions and inspected as required, has the potential to hinder system performance during a fire event. This deficient practice affected 47 residents and staff on the date of the survey.</td>
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<td>Findings include:</td>
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<tr>
<td>During review of provided maintenance and inspection records conducted on 1/23/20 from 8:45 - 11:00 AM, records failed to indicate the facility was performing monthly control valve inspections of the fire suppression system.</td>
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<tr>
<td>Actual NFPA standard:</td>
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<tr>
<td>NFPA 25</td>
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<tr>
<td>13.3 Control Valves in Water-Based Fire Protection Systems.</td>
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<tr>
<td>13.3.2 Inspection.</td>
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</table>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER: 135092

(X2) MULTIPLE CONSTRUCTION
A. BUILDING 02 - ENTIRE STRUCTURE
B. WING __________

(X3) DATE SURVEY COMPLETED 01/23/2020

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - IDAHO FALLS 840 EAST ELVA STREET
IDAHO FALLS, ID 83401

(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) COMPLETION DATE

K 353 Continued From page 9
13.3.2.1 All valves shall be inspected weekly.
13.3.2.1.1 Valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly.

K 374 Subdivision of Building Spaces - Smoke Barrier Doors
SS=D CFR(s): NFPA 101

Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING
Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors.
19.3.7.6, 19.3.7.8, 19.3.7.9
This REQUIREMENT is not met as evidenced by:
Based on observation, operational testing and interview, the facility failed to ensure required self-closing doors in smoke barriers, would fully self-close and resist the passage of smoke in the time required. Failure to ensure the self-closing operation of smoke barrier doors is completed in the time designed, has the potential to allow fire, smoke and dangerous gases to pass between smoke compartments during a fire event. This deficient practice affected 3 residents and staff on the date of the survey.

Findings include:
During the facility tour conducted on 1/23/20 from

K 353

K 374
It was determined that one smoke barrier door, located outside room 214, did not self-close as designed. The facility environmental service director or designee will replace the closing mechanism with a new one, and then verify that the smoke barrier door closing speed shall not be less than 6in./sec, not including any initial delay time.

After the corrective action, no additional residents, staff, or visitors should be affected by the deficiency.

The facility environmental service director or designee will verify that during the routine inspections of smoke barrier doors that the closing speed is in compliance per NFPA 80

The environmental service director or designee will report the results of the smoke barrier door checks to the facility safety committee - which reports to the QAPI committee.

The corrective action will be completed by: 2/27/2020

MEQK21
### SUMMARY STATEMENT OF DEFICIENCIES

#### K374

Continued From page 10

11:00 AM - 2:30 PM, observation and operational testing of the smoke barrier doors located outside room 214, revealed that when released from the magnetic hold-open device, the door leaf on the south side of the opening, swung freely until reaching a point of approximately ten inches from fully self-closing with the adjacent leaf, then the closing speed slowed to approximately one-tenth of an inch per second. Further observation revealed an approximately two-inch gap between the two (2) doors was still remaining after a time lapse of approximately eighty seconds.

At approximately 2:00 PM, interview of the Maintenance Director on the substantial time delay in this self-closing operation, established he knew the doors were not self-closing as designed prior to the survey date.

Actual NFPA standard:

**NFPA 101**

19.3.7.8* Doors in smoke barriers shall comply with 8.5.4 and all of the following:

1. The doors shall be self-closing or automatic-closing in accordance with 19.2.2.2.7.
2. Latching hardware shall not be required
3. The doors shall not be required to swing in the direction of egress travel.

**NFPA 105**

Standard for Smoke Door Assemblies and Other Opening Protectives

4.5 Installation.

4.5.1 Smoke doors shall be self-closing or automatic closing in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives.
### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CUA Identification Number:** 135092

**Multiple Construction**

A. Building 02 - Entire Structure

B. Wing

**Date Survey Completed:** 01/23/2020

**Name of Provider or Supplier:** Good Samaritan Society - Idaho Falls

**Street Address, City, State, Zip Code:** 840 East Elva Street, Idaho Falls, ID 83401

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</th>
</tr>
</thead>
</table>
| K 374 | Continued From page 11 | NFPA 80
8.4.1 Closing Devices.
8.4.1.1 Doors shall be equipped with self-closing or automatic closing devices to ensure that they shall close or be closed at the time of a fire.

8.4.1.2 Closing Speed.
8.4.1.2.1 The average closing speed shall be not less than 6 in./sec (152 mm/sec), not including any initial delay time. |

| K 511 | Utilities - Gas and Electric | CFR(s): NFPA 101
Utilities - Gas and Electric
Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life.

18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 |

This REQUIREMENT is not met as evidenced by:
Based on observation, the facility failed to ensure electrical installations were installed in accordance with NFPA 70. Two soap washing machine soap dispensers were plugged into a RPT. The facility will remove the RPT used to power the washing machine soap dispensers. The facility will also contract with an electrician to install two new outlets that will be used to supply power instead of the RPT.

After the corrective action, no additional residents, staff, or visitors should be affected by the deficiency.

The facility environmental service director or designee will perform annual inspections of the facility outlets in accordance with NFPA 70.

The environmental service director or designee will report the results of the annual inspections to the facility safety committee - which reports to the QAPI committee.

The corrective action will be completed by: 2/27/2020

Findings include:
During the facility tour conducted on 1/23/20 from K 374.

K 511
It was determined that the facility failed to ensure electrical installations were installed in accordance with NFPA 70. Two soap washing machine soap dispensers were plugged into a RPT. The facility will remove the RPT used to power the washing machine soap dispensers. The facility will also contract with an electrician to install two new outlets that will be used to supply power instead of the RPT.

After the corrective action, no additional residents, staff, or visitors should be affected by the deficiency.

The facility environmental service director or designee will perform annual inspections of the facility outlets in accordance with NFPA 70.

The environmental service director or designee will report the results of the annual inspections to the facility safety committee - which reports to the QAPI committee.

The corrective action will be completed by: 2/27/2020

<table>
<thead>
<tr>
<th>K 511</th>
<th>Utilities - Gas and Electric</th>
<th>K 511</th>
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<tr>
<td>SS=D</td>
<td>Utilities - Gas and Electric</td>
<td>K511</td>
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</table>
| | Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life.

18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 |

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K 511
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The environmental service director or designee will report the results of the annual inspections to the facility safety committee - which reports to the QAPI committee.

The corrective action will be completed by: 2/27/2020

Findings include:
During the facility tour conducted on 1/23/20 from K 511.
### SUMMARY STATEMENT OF DEFICIENCIES

**K 511 Continued From page 12**

11:00 AM - 2:30 PM, observation of the main Laundry revealed a RPT was being used to supply power to the industrial washing machine soap dispensers. Further observation revealed the cord to the RPT was zip-tied to the metal conduit for the facility outlet.

**Actual NFPA standard:**

**NFPA 70**

110.3 Examination, Identification, Installation, and Use of Equipment.

(A) Examination. In judging equipment, considerations such as the following shall be evaluated:

(1) Suitability for installation and use in conformity with the provisions of this Code Informational Note: Suitability of equipment use may be identified by a description marked on or provided with a product to identify the suitability of the product for a specific purpose, environment, or application. Special conditions of use or other limitations and other pertinent information may be marked on the equipment, included in the product instructions, or included in the appropriate listing and labeling information. Suitability of equipment may be evidenced by listing or labeling.

(2) Mechanical strength and durability, including, for parts designed to enclose and protect other equipment, the adequacy of the protection thus provided.

(3) Wire-bending and connection space

(4) Electrical insulation

(5) Heating effects under normal conditions of use and also under abnormal conditions likely to arise in service

(6) Arcing effects

(7) Classification by type, size, voltage, current
<table>
<thead>
<tr>
<th>Provider Identification Number: 135092</th>
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<tbody>
<tr>
<td>Multiple Construction</td>
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<tr>
<td>A. Building 02 - Entire Structure</td>
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<tr>
<td>B. Wing ____________________________</td>
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</tbody>
</table>

**Date Survey Completed:** 01/23/2020

**Name of Provider or Supplier:** Good Samaritan Society - Idaho Falls

**Address:** 840 East Elva Street, Idaho Falls, ID 83401

### Summary Statement of Deficiencies

#### K 511

Continued From page 13

1. Capacity, and specific use
2. Other factors that contribute to the practical safeguarding of persons using or likely to come in contact with the equipment.
3. Installation and Use. Listed or labeled equipment shall be installed and used in accordance with any instructions included in the listing or labeling.
4. 400.8 Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following:
   1. As a substitute for the fixed wiring of a structure
   2. Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors
   3. Where run through doorways, windows, or similar openings
   4. Where attached to building surfaces
   5. Exception to (4): Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of 368.56(B)
   6. Where concealed by walls, floors, or ceilings or located above suspended or dropped ceilings
   7. Where installed in raceways, except as otherwise permitted in this Code

Further reference: UL 1363 XBYS

#### K 521

- HVAC
- CFR(s): NFPA 101

- HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2

#### K 521

- The facility failed to ensure maintenance of installed fire dampers in accordance with NFPA 101. To correct this deficiency, the environmental service director will contract with electricians and/or HVAC service providers to troubleshoot and repair/replace the non-functioning fire dampers.
### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CA/CLA Identification Number:** 135092  
**Multiple Construction:**  
A. Building 02 - Entire Structure  
B. Wing ___  
**Multiple Survey Completed:** 01/23/2020

**Name of Provider or Supplier:** Good Samaritan Society - Idaho Falls  
**Address:** 840 East Elva Street, Idaho Falls, ID 83401

**ID Prefix Tag** | **Summary Statement of Deficiencies** | **Provider's Plan of Correction** | **Completion Date**
--- | --- | --- | ---
K 521 | Continued From page 14 | K 521 |  
**Actual NFPA Standard:**  
NFPA 101  
9.2.1 Air-Conditioning, Heating, Ventilating Ductwork, and Related Equipment. Air conditioning, heating, ventilating ductwork, and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems, or NFPA 90B, Standard for the Installation of Warm Air Heating and Air-Conditioning Systems, as applicable, unless such installations are approved existing installations, which shall be permitted to

**Findings include:**  
During review of the maintenance and inspection records conducted on 1/23/20 from 8:30 - 11:00 AM, provided fire damper inspection records dated 4/25/19, indicated 2 of 3 fire dampers identified and tested in the "Helping Hands" area of the building, were found to be without power and inoperable.

**Corrective Action:**  
After the corrective action, no additional residents, staff, or visitors should be affected by the deficiency.  
The facility environmental service director or designee will ensure that during future damper inspections that if a damper is identified as non-operational that repair should be made without delay – per NFPA 80.  
The environmental service director or designee will report the results of the damper repair to the facility safety committee – which reports to the QAPI committee.  
The corrective action will be completed by: 2/27/2020
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER: 135092

(X2) MULTIPLE CONSTRUCTION
A. BUILDING 02 - ENTIRE STRUCTURE

B. WING

(X3) DATE SURVEY COMPLETED
01/23/2020

NAME OF PROVIDER OR SUPPLIER
GOOD SAMARITAN SOCIETY - IDAHO FALLS

STREET ADDRESS, CITY, STATE, ZIP CODE
840 EAST ELVA STREET
IDAHO FALLS, ID 83401

(X4) ID PREFIX TAG
K 521 Continued From page 15 be continued in service.

NFPA 90A
5.4.8 Maintenance.
5.4.8.1 Fire dampers and ceiling dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives.

NFPA 80
19.5 Maintenance.
19.5.3 If the damper is not operable, repairs shall begin without delay.

K 923 Gas Equipment - Cylinder and Container Storag 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 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.

K 521

K 923 It was determined that the facility failed to ensure medical gas storage was in accordance with NFPA 99. Specifically, two staff members could not determine what the state of the oxygen cylinders were in the EMPTY and FULL racks.

To correct this deficiency, Lincare, on 2/6/2020 will provide in-service to the facility clinical and maintenance staff on the proper method for identifying if an O2 cylinder is empty or full.

After the corrective action, no additional residents, staff, or visitors should be affected by the deficiency.

The facility clinical learning RN will show all new clinical staff how to check the status of the O2 cylinders, and the Lincare will provide step-by-step signage/instructions to post in the gas storage room.
<table>
<thead>
<tr>
<th>ID</th>
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<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>K 923</td>
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<td>Continued From page 16</td>
<td>K 923</td>
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<td>The facility QAPI coordinator will perform quarterly checks – to ensure that new and current staff know the proper method for checking the status of O2 cylinders. The corrective action was completed on: 2/6/2020</td>
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</table>

A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather.

11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)

This REQUIREMENT is not met as evidenced by:

Based on observation, operational testing and interview, the facility failed to ensure medical gas storage was in accordance with NFPA 99. Failure to secure and segregate medical gas cylinders such as oxygen has the potential to increase the exposure to fires and explosions associated with the unsafe handling of medical gases. This deficient practice affected those residents reliant on oxygen and staff on the date of the survey.

During the facility tour conducted on 1/23/20 from 11:00 AM - 2:30 PM, observation of the oxygen storage area in the 100 hall med room, revealed two (2) separated storage racks, each with individual signage designating the rack as either "Full" or "Empty". Further observation could not determine the state of stored cylinders in these racks, as each of the six (6) cylinders appeared to be similar, with regulators installed on two (2) cylinders in the "Full" rack and one (1) in the "Empty". Further observation revealed all three regulators had a "zero" pressure indication on the gauge.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:**

135092

**MULTIPLE CONSTRUCTION**

A. BUILDING 02 - ENTIRE STRUCTURE
B. WING

**DATE SURVEY COMPLETED:**

01/23/2020

---

**NAME OF PROVIDER OR SUPPLIER:**

GOOD SAMARITAN SOCIETY - IDAHO FALLS

**STREET ADDRESS, CITY, STATE, ZIP CODE:**

840 EAST ELVA STREET
IDAHO FALLS, ID 83401

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<tr>
<td>K 923</td>
<td>Interview at approximately 1:45 PM of the on-duty nurse as to how to identify full cylinders from an empty cylinders, established the staff would open the valve on the regulator and inspect the gauge to determine if a cylinder still had gas pressure. Observation of the nurse performing this operational testing on the cylinders stored in the &quot;Full&quot; rack, revealed one of the two stored cylinders with regulators attached, had no pressure on the gauge when the valve was fully opened and was identified by this nurse as being an &quot;Empty&quot; cylinder.</td>
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**ID PREFIX TAG**

K 923

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<tr>
<td>K 927</td>
<td>It was found that in the oxygen storage area, ten LOX cylinders were not secured by a chain, rack, or cart. It was also found that the exhaust fan in the transfill room was operational but lacked sufficient exhaust to discharge gases from the space. To correct the first deficiency, the environmental service director installed the chain across the front of the LOX cylinders - it was sitting on the floor. All clinical staff, who fill portable 02 units from the cylinders, were provided training at the all-staff meeting on 2/6/2020 with instructions on how to ensure that the retaining chain should be installed. To correct the second deficiency, the environmental service director will install a new exhaust fan and then test to verify sufficient exhaust.</td>
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**ID PREFIX TAG**

K 927
Based on observation, operational testing and interview, the facility failed to ensure medical gas storage and operations, such as transfilling, were in accordance with NFPA 99. Failure to secure liquid oxygen (LOX) and provide sufficient mechanical ventilation for transfilling operations, has the potential to increase the exposure to fires and explosions associated with the unsafe handling of medical gases. This deficient practice affected those residents reliant on oxygen and staff on the date of the survey.

Findings include:

1) During the facility tour conducted on 1/23/20 from 11:00 AM - 2:30 PM, observation of the oxygen storage area in the 100 hall med room, revealed ten (10) LOX cylinders not secured by a chain, rack or cart.

2) During the facility tour conducted on 1/23/20 from 11:00 AM - 2:30 PM, observation and operational testing of the exhaust fan in the oxygen transfill room located at the entrance to the 300 hall, revealed the fan was on and operational, but lacked sufficient exhaust to discharge gases from the space when tested placing a standard sheet of note paper against the face of the exhaust fan grille.

NFPA 99

9.3.7.5.3.2 Mechanical exhaust shall be at a rate of 1 L/sec of airflow for each 300 L (1 cfm per 5 ft³ of fluid) designed to be stored in the space and not less than 24 L/sec (50 cfm) nor more than 235 L/sec (500 cfm).

11.6.2.3 Cylinders shall be protected from...
damage by means of the following specific procedures:

1. Oxygen cylinders shall be protected from abnormal mechanical shock, which is liable to damage the cylinder, valve, or safety device.
2. Oxygen cylinders shall not be stored near elevators or gangways or in locations where heavy moving objects will strike them or fall on them.
3. Cylinders shall be protected from tampering by unauthorized individuals.
4. Cylinders or cylinder valves shall not be repaired, painted, or altered.
5. Safety relief devices in valves or cylinders shall not be tampered with.
6. Valve outlets clogged with ice shall be thawed with warm - not boiling - water.
7. A torch flame shall not be permitted, under any circumstances, to come in contact with a cylinder, cylinder valve, or safety device.
8. Sparks and flame shall be kept away from cylinders.
9. Even if they are considered to be empty, cylinders shall not be used as rollers, supports, or for any purpose other than that for which the supplier intended them.
10. Large cylinders (exceeding size E) and containers larger than 45 kg (100 lb) weight shall be transported on a proper hand truck or cart complying with 11.4.3.1.
11. Freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart.
12. Cylinders shall not be supported by radiators, steam pipes or heat ducts.

11.7.3.3* Liquid oxygen base reservoir containers shall be secured by one of the following methods while in storage or use to prevent tipping over caused by contact, vibration, or seismic activity:
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(1) Securing to a fixed object with one or more restraints
(2) Securing within a framework, stand, or assembly designed to resist container movement
(3) Restraining by placing the container against two points of contact

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
January 31, 2020

Craig Perez, Administrator
Good Samaritan Society - Idaho Falls Village
840 East Elva Street
Idaho Falls, ID 83401-2899

Provider #: 135092

RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER

Dear Mr. Perez:

On January 23, 2020, an Emergency Preparedness survey was conducted at Good Samaritan Society - Idaho Falls 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 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. 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 February 13, 2020. Failure to submit an acceptable PoC by February 13, 2020, may result in the imposition of civil monetary penalties by March 6, 2020.

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 February 27, 2020, (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 March 16, 2020, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by February 27, 2020, includes the following:

- Denial of payment for new admissions effective April 23, 2020.
  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 **July 23, 2020**, 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 **January 23, 2020**, 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:


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 **February 13, 2020**. If your request for informal dispute resolution is received after **February 13, 2020**, 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,

[Signature]

Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosures
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES  
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  

(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:  
135092  

(X2) MULTIPLE CONSTRUCTION  
A. BUILDING  
B. WING  

(X3) DATE SURVEY COMPLETED  
01/23/2020  

NAME OF PROVIDER OR SUPPLIER  
GOOD SAMARITAN SOCIETY - IDAHO FALLS  
STREET ADDRESS, CITY, STATE, ZIP CODE  
840 EAST ELVA STREET  
IDAHO FALLS, ID 83401  

(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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<th>E 000</th>
<th>Initial Comments</th>
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<tr>
<td>The facility is a single story, Type V (111) structure, originally constructed in 1964 and located within a municipal fire district, with both county and state EMS services available. The facility is fully sprinklered with an interconnected fire alarm/smoke detection system. The partial basement houses mechanical equipment and the on-site, diesel-fired Emergency Power Supply System (EPSS) generator. The facility is currently licensed for 113 SNF/NF beds with a census of 47 on the date of the survey.</td>
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The following deficiencies were cited during the emergency preparedness survey conducted on January 23, 2020. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73.

The Survey was conducted by:

Sam Burbank  
Health Facility Surveyor  
Facility Fire Safety and Construction

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<tr>
<th>E 030</th>
<th>Names and Contact Information</th>
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<td>SS=D</td>
<td>CFR(s): 483.73(c)(1)</td>
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[(c) The facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years (annually for LTC).] The communication plan must include all of the following:

1. Names and contact information for the following:
   i. Staff.
   ii. Entities providing services under arrangement.
   iii. Patients' physicians.

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 center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7395 of the State Operations Manual.

E 030  
The facility was found to have "failed to demonstrate a communication plan that included contact information for volunteers." The facility will document a communication plan that includes contact information for various volunteer agencies that can assist in the facility's response and recovery during a disaster.

After the corrective action, no additional residents, staff, or visitors should be affected by the deficiency.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
Administrator  
2/11/2020  

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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<td>(iv) Other [facilities].</td>
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<td>(v) Volunteers.</td>
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<td>*[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers.</td>
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<td>*[For RNHCl at §403.748(c); The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCl. (v) Volunteers.]</td>
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<td>*[For ASCs at §416.45(c); The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers.]</td>
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<td>*[For Hospices at §418.113(c); The communication plan must include all of the following:</td>
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The corrective action will be completed by: 2/27/2020
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(1) Names and contact information for the following:
   (i) Hospice employees.
   (ii) Entities providing services under arrangement.
   (iii) Patients' physicians.
   (iv) Other hospices.

*[For HHAs at §484.102(c):] The communication plan must include all of the following:
(1) Names and contact information for the following:
   (i) Staff.
   (ii) Entities providing services under arrangement.
   (iii) Patients' physicians.
   (iv) Volunteers.

*[For OPOs at §486.360(c):] The communication plan must include all of the following:
(2) Names and contact information for the following:
   (i) Staff.
   (ii) Entities providing services under arrangement.
   (iii) Volunteers.
   (iv) Other OPOs.
   (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA).

This REQUIREMENT is not met as evidenced by:
Based on record review, the facility failed to document a communication plan which included contact information for staff, resident physicians, other long-term care facilities and applicable volunteer agencies. Failure to have a communication plan which includes contact information for those volunteers, including those credentialed federal and state agencies capable of assisting in the facility's response and recovery.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER: 135092

MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

STATE DATE SURVEY COMPLETED
01/23/2020

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - IDAHO FALLS 840 EAST ELVA STREET IDAHO FALLS, ID 83401

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) COMPLETION DATE

E 030 Continued From page 3 during a disaster, has the potential to hinder both internal and external emergency response efforts. This deficient practice affected 47 residents, staff and visitors on the date of the survey.

Findings include:

On 1/23/20 from 8:45 - 10:30 AM, review of the provided EP policies and procedures, failed to demonstrate a communication plan that included contact information for volunteers.

Reference:
42 CFR 483.73 (c) (1)

Emergency Officials Contact Information
[The facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years (annually for LTC).] The communication plan must include all of the following:

(2) Contact information for the following:
   (i) Federal, State, tribal, regional, and local emergency preparedness staff.
   (ii) Other sources of assistance.

*For LTC Facilities at §483.73(c):] (2) Contact information for the following:
   (i) Federal, State, tribal, regional, and local emergency preparedness staff.
   (ii) The State Licensing and Certification Agency.
   (iii) The Office of the State Long-Term Care Ombudsman.
   (iv) Other sources of assistance.

*For ICF/IIDs at §483.475(c):] (2) Contact

E 031 E 031
The facility was found to have "failed to establish a communication plan was included that provided contact information for the state licensing and certification agency and the state ombudsman." The facility will document a communication plan that includes contact information for the state licensing and certification agency and state ombudsman.

After the corrective action, no additional residents, staff, or visitors should be affected by the deficiency.

The environmental services director or designee will update the emergency preparedness communication plan annually – verifying that proper contact information is provided for the required entities.
**E 031** Continued From page 4:

Information for the following:

(i) Federal, State, tribal, regional, and local emergency preparedness staff.

(ii) Other sources of assistance.

(iii) The State Licensing and Certification Agency.

(iv) The State Protection and Advocacy Agency.

This REQUIREMENT is not met as evidenced by:

Based on record review, the facility failed to ensure the EP had a communication plan that provided contact information for emergency management officials and other resources of assistance. Failure to provide contact information for federal agencies, local emergency preparedness staff, state licensing and certification agency, state ombudsman and other sources of assistance, has the potential to hinder facility response and continuity of care for the 47 residents, staff and visitors in the facility on the date of the survey.

Findings include:

On 1/23/20 from 8:45 - 10:30 AM, review of the provided EP, failed to establish a communication plan was included that provided contact information for the state licensing and certification agency and the state ombudsman.

Reference:

42 CFR 483.73 (c) (2)

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The environmental service director will schedule an annual review of the facility emergency preparedness communication plan – to be completed by the facility administrator and environmental service director. Changes and updates will be reported to the facility safety committee – which reports to the QAPI committee.

The corrective action will be completed by: 2/27/2020