



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

.BRAD LITTLE – Governor  
DAVE JEPPESEN – Director

TAMARA PRISOCK – ADMINISTRATOR  
DIVISION OF LICENSING & CERTIFICATION  
DEBRA RANSOM, R.N., R.H.I.T., Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0009  
PHONE 208-334-6626  
FAX 208-364-1888

February 8, 2019

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 30, 2019**, 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 21, 2019**. Failure to submit an acceptable PoC by **February 21, 2019**, may result in the imposition of civil monetary penalties by **March 14, 2019**.

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 **March 6, 2019**, (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 30, 2019**. A change in the seriousness of the deficiencies on **March 16, 2019**, may result in a change in the remedy.

Craig Perez, Administrator  
February 7, 2019  
Page 3 of 4

The remedy, which will be recommended if substantial compliance has not been achieved by **March 6, 2019**, includes the following:

Denial of payment for new admissions effective **April 30, 2019**.  
42 CFR §488.417(a)

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **July 30, 2019**, if substantial compliance is not achieved by that time.

**Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.**

If you believe these deficiencies have been corrected, you may contact Nate Elkins, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, option 3; Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **January 30, 2019**, 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:

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<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

Go to the middle of the page to Information Letters section and click on State and select the following:

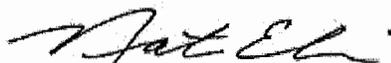
BFS Letters (06/30/11)

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

This request must be received by **February 21, 2019**. If your request for informal dispute resolution is received after **February 21, 2019**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626, option 3.

Sincerely,



Nate Elkins, Supervisor  
Facility Fire Safety and Construction

NE/lj  
Enclosures

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

PRINTED: 02/07/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135092</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02</b> - ENTIRE STRUCTURE  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/30/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - IDAHO FALLS VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>840 EAST ELVA STREET IDAHO FALLS, ID 83401</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
K 000	INITIAL COMMENTS  The facility is a single story, Type V (111) construction with a partial basement. Original construction was June 1964 with an addition in 1985 and a major renovation in 1995. A new fire alarm/smoke detection system was installed in November 2009. The facility is fully sprinklered with smoke detection coverage throughout the facility including sleeping rooms located in the 1985 addition. Sleeping rooms in the original building do not have smoke detection coverage. The partial basement is a mechanical room with interior and exterior access. The Essential Electrical System is supplied by a diesel powered, on-site automatic generator. The facility is situated in a municipal fire district and is currently licensed for 113 SNF/NF beds with a census of 44 on the dates of the survey.  The following deficiencies were cited during the annual fire/life safety survey conducted on January 29 - 30, 2019. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70, and 42 CFR 483.80.  The survey was conducted by:  Linda Chaney Health Facility Surveyor Facility Fire Safety and Construction	K 000	(see attached)	
K 232 SS=F	Aisle, Corridor, or Ramp Width CFR(s): NFPA 101  Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at	K 232		

RECEIVED  
FEB 20 2018  
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Craig Perez* TITLE Craig Perez, Administrator (X6) DATE 2/19/2019

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.

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K 232	<p>Continued From page 1</p> <p>least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, the facility failed to maintain corridor exit access free of obstructions. Failure to maintain exit access width in the path of travel, could hinder the safe evacuation of residents during a fire or other emergency. This deficient practice affected 44 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour on January 30, 2019, from approximately 8:00 AM to 12:00 PM, observation of the exit access corridors revealed wall sconce light fixtures projecting from the corridor wall approximately 6 inches at a height of approximately 71 inches from the floor. The light fixtures were located throughout the facility, all exceeding the 4 inches allowed by ADA Standards. When asked, the Environmental Services Director stated the facility was unaware of the requirements for non-continuous projections in the corridor.</p> <p>Actual NFPA Standard:</p> <p>19.2.3.4* Any required aisle, corridor, or ramp shall be not less than 48 in. (1220 mm) in clear width where serving as means of egress from patient sleeping rooms, unless otherwise permitted by one of the following: (1) Aisles, corridors, and ramps in adjunct areas</p>	K 232			

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K 232	Continued From page 2 not intended for the housing, treatment, or use of inpatients shall be not less than 44 in. (1120 mm) in clear and unobstructed width. (2) *Where corridor width is at least 6 ft (1830 mm), non-continuous projections not more than 6 in. (150 mm) from the corridor wall, above the handrail height, shall be permitted. (3) Exit access within a room or suite of rooms complying with the requirements of 19.2.5 shall be permitted. (4) Projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in. (1525 mm). (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c)*The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment (5) *Where the corridor width is at least 8 ft (2440 mm), projections into the required width shall be permitted for fixed furniture, provided that all of the following conditions are met: (a) The fixed furniture is securely attached to the floor or to the wall. (b) The fixed furniture does not reduce the clear unobstructed corridor width to less than 6 ft (1830 mm), except as permitted by 19.2.3.4(2). (c) The fixed furniture is located only on one side of the corridor. (d) The fixed furniture is grouped such that each grouping does not exceed an area of 50 ft <sup>2</sup> (4.6	K 232			

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K 232	Continued From page 3 m2). (e) The fixed furniture groupings addressed in 19.2.3.4(5)(d) are separated from each other by a distance of at least 10 ft (3050 mm). (f)*The fixed furniture is located so as to not obstruct access to building service and fire protection equipment. (g) Corridors throughout the smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the fixed furniture spaces are arranged and located to allow direct supervision by the facility staff from a nurses' station or similar space. (h) The smoke compartment is protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.8.  CMS Final Rule:  SECTIONS 18.2.3.4(2) AND 19.2.3.4(2)-CORRIDOR PROJECTIONS This provision requires non-continuous projections to be no more than 6 inches from the corridor wall. In addition to following the requirements of the LSC, health care facilities must comply with the requirements of the ADA, including the requirements for protruding objects. The 2010 Standards for Accessible Design (2010 Standards) generally limit the protrusion of wall-mounted objects into corridors to no more than 4 inches from the wall when the object's leading edge is located more than 27 inches, but not more than 80 inches, above the floor.	K 232			
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101  Sprinkler System - Maintenance and Testing	K 353			

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K 353	<p>Continued From page 4</p> <p>Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure fire suppression system pendants were maintained free of obstructions such as paint or corrosion. Failure to maintain fire sprinkler pendants free of obstructions could hinder system performance during a fire event. This deficient practice affected staff and visitors in the medical records office on the dates of the survey.</p> <p>Findings include:</p> <p>Observation during the facility tour on January 30, 2019, from approximately 8:00 AM to 12:00 PM, revealed the sprinkler head in the bathroom off of the medical records office had paint on it. When asked, the Environmental Services Director stated the facility was not aware that the sprinkler had been painted.</p>	K 353		

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K 353	Continued From page 5  Actual NFPA standard:  NFPA 25 5.2.1 Sprinklers. 5.2.1.1* Sprinklers shall be inspected from the floor level annually. 5.2.1.1.1* Sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., upright, pendent, or sidewall). 5.2.1.1.2 Any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical damage (4) Loss of fluid in the glass bulb heat responsive element (5)*Loading (6) Painting unless painted by the sprinkler manufacturer	K 353		
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101  Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that	K 363		

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K 363	<p>Continued From page 6</p> <p>do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.</p> <p>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485</p> <p>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, operational testing, and interview the facility failed to maintain doors that protect corridor openings. Failure to maintain corridor doors could allow smoke and dangerous gases to pass freely, preventing defend in place. This deficient practice has the potential to affect 4 residents, staff, and visitors on the dates of the survey.</p> <p>Findings include:</p> <p>During the facility tour on January 30, 2019, from approximately 8:00 AM to 12:00 PM, observation</p>	K 363			

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K 363	<p>Continued From page 7 and operational testing of resident room doors revealed the following:</p> <ol style="list-style-type: none"> <li>1.) Resident rooms #101 and #104 each had an approximately 3/4" gap between the face of the door and frame of the door when fully closed.</li> <li>2.) Resident room #109 had an approximately 1" gap between the face of the door and the frame of the door when fully closed.</li> <li>3.) Resident room #215 had an approximately 7/8" gap between the face of the door and the frame of the door when fully closed.</li> </ol> <p>When asked, the Environmental Services Director stated the facility was unaware 1/2" was the maximum distance allowed between the face and frame of a resident room door when fully closed.</p> <p>Actual NFPA Standards:</p> <p>NFPA 101 19.3.6.3* Corridor Doors. 19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be doors constructed to resist the passage of smoke and shall be constructed of materials such as the following: (1) 1-3/4 in. (44 mm) thick, solid-bonded core wood (2) Material that resists fire for a minimum of 20 minutes</p> <p>Additional Reference:</p> <p>Centers for Medicare/Medicaid Services S&amp;C Letter 07-18, Permittable Door Gaps.</p>	K 363			

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K 511 K 511 SS=F	Continued From page 8 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 and interview, the facility failed to ensure that electrical systems were installed and used in accordance with NFPA 70. Failure to ensure proper electrical installations and use could result in electrocution or fire. This deficient practice affected 44 residents, staff and visitors on the dates of the survey.  Findings include:  During the facility tour on January 30, 2019, from approximately 8:00 AM to 12:00 PM, observation of the facility revealed the following:  1.) Resident room #131 had a broken outlet in use. 2.) The aquarium in the dining room had a daisy chain, Relocatable Power Tap (RPT) to RPT with aquarium equipment plugged in to the RPTs.  When asked, the Environmental Services Director stated the facility was unaware of these	K 511 K 511			

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

PRINTED: 02/07/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135092</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE STRUCTURE  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/30/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - IDAHO FALLS VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>840 EAST ELVA STREET IDAHO FALLS, ID 83401</b>		
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K 511	Continued From page 9 electrical deficiencies.  Actual NFPA standard:  NFPA 70 400.8 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 Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of 368.8. (5) Where concealed by walls, floors, or ceilings or located above suspended or dropped ceilings (6) Where installed in raceways, except as otherwise permitted in this Code	K 511			
K 712 SS=F	Fire Drills CFR(s): NFPA 101  Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.	K 712			

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NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY - IDAHO FALLS VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 840 EAST ELVA STREET IDAHO FALLS, ID 83401		
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K 712	<p>Continued From page 10 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide documentation of fire drills on all shifts quarterly. Failure to perform fire drills on each shift quarterly could result in confusion and hinder the safe evacuation of residents during a fire event. This deficient practice affected 44 residents, staff and visitors on the dates of survey.</p> <p>Findings Include:</p> <p>During record review conducted at the facility on January 29, 2019, from approximately 10:00 AM to 2:00 PM, review of the fire drill reports revealed that the facility was missing fire drill documentation on first shift for fourth quarter 2018. When asked, the Environmental Services Director stated that he was new to his position and was unaware that fire drills had not been performed as required.</p> <p>Actual NFPA Standard:</p> <p>NFPA 101</p> <p>19.7.1.4* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions.</p> <p>19.7.1.6 Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions.</p>	K 712			

*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 7305 of the State Operations Manual.*

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## **K232 Aisle, Corridor, or Ramp Width**

**1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?**

The center was found to have decorative wall sconce lighting fixtures throughout the facility which projected into the corridors further than the 4 inches allowed by ADA standards. This deficiency was identified as affecting all residents, staff, and visitors on the date of the survey. To correct this deficiency all identified lighting fixtures will be removed by the environmental services director or designee.  
(Completed 2/7/2019)

**2. How will other residents, having the potential to be affected by the same deficient practice, be identified?**

All deficient protrusions were identified during the survey process, and correcting the current deficiency will eliminate the potential for harm to all residents, staff, and visitors.

**3. What measures will be put into place, or what systemic changes will be made to ensure that the deficient practice does not recur?**

The environmental services director will provide in-service for all environmental service staff to review the standards of K232, including, but not limited to the requirements for non-continuous projections into the corridor.

**4. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur?**

The environmental services director will schedule and perform semi-annual audits, verifying that the facility remains in compliance with the requirements of K232, including, but not limited to the requirements for non-continuous projections into the corridor.

**5. What is the date of completion?**

Completed 2/7/2019 by the facility maintenance department. Please accept this as the facility's allegation of compliance.

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### K353 SprinklerSystem – Maintenance and Testing

**1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?**

The center was found to have one fire suppression pendant which was painted and not free of obstructions. To correct this deficiency, the identified pendant will be replaced with a new one. (Completed 2/7/2019)

**2. How will other residents, having the potential to be affected by the same deficient practice, be identified?**

All deficient obstructions were identified during the survey process. However, an additional audit will be performed by the environmental services director on 2/19/19, and will be based on the inspection guidelines listed in NFPA 25, sec. 5.2.1. Any self-identified deficiencies will be immediately corrected.

**3. What measures will be put into place, or what systemic changes will be made to ensure that the deficient practice does not recur?**

Painting is performed in this facility both by facility staff members as well as contractors. The environmental services director will modify the facility painting record log to include a reminder to not paint over any fire suppression pendant, smoke detector, fire alarm, or door fire rating badge. A check will be performed after every painting job to ensure compliance and will be recorded in the painted log.

**4. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur?**

The environmental services director will schedule semi-annual audits based on the inspection guidelines listed in NFPA 25, sec. 5.2.1.

**5. What is the date of completion?**

Completed 2/19/2019 by 3D Fire Protection of Idaho Falls, ID. Please accept this as the facility's allegation of compliance.

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### K363 Corridor - Doors

**1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?**

The center was found to have four resident room doors which, due to a gap between the face of the door and frame of the door, would potentially fail to resist the passage of smoke and/or dangerous gasses. This deficiency was identified as affecting the residents in those four rooms, plus staff and visitors. To correct this deficiency, the facility has contracted with Architectural Building Supply of Idaho Falls, ID. They tried to adjust the doors on Monday, 2/18/19 but were unable to. Therefore, the facility is ordering 4 new doors to replace the defective

ones. ABS said that it will take 5+ weeks to get the doors in. The facility is requesting an extension until 4/6/2019

**2. How will other residents, having the potential to be affected by the same deficient practice, be identified?**

All deficient door gaps were identified during the survey process, and correcting the current deficiency will eliminate the potential for harm to all residents, staff, and visitors. However, an additional audit of doors will be performed by the environmental services director on 2/18/19. Any self-identified deficiencies will be immediately corrected.

**3. What measures will be put into place, or what systemic changes will be made to ensure that the deficient practice does not recur?**

The environmental services director or designee will provide in-service for all facility staff – informing them of how to identify and report issues with doors, such as sticking and door gaps.

**4. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur?**

The environmental services director will schedule and perform semi-annual audits, verifying that the facility remains in compliance with the requirements of K363.

**5. What is the date of completion?**

New doors were ordered on 2/19/2019. Due to the build time of the order, the facility formally requests an extension for compliance until 4/6/2019.

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## K511 Utilities – Gas and Electric

**1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?**

A) The center was found to have a broken outlet in use in room #131. This outlet was replaced with a new one on 1/30/2019.

B) The aquarium in the dining room had a daisy-chain RPT to RPT with aquarium equipment plugged into the RPTs. The facility contracted with Sermon Service & Electric of Idaho Falls, ID to install dedicated outlets for each piece of aquarium equipment. This was done not only for the aquarium in the dining room, but for the aquarium in the TV lounge as well. Work was completed on 2/12/19.

**2. How will other residents, having the potential to be affected by the same deficient practice, be identified?**

The electrical deficiency identified during the survey process has been corrected, in addition to a second aquarium not noted during the survey. The facility environmental service director will perform a facility wide audit on 2/18/19, to identify any additional deficiencies.

**3. What measures will be put into place, or what systemic changes will be made to ensure that the deficient practice does not recur?**

The environmental services director or designee will provide in-service for all facility staff – informing them of how to identify and report issues with electrical outlets and incorrect electrical cord usage.

**4. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur?**

The environmental services director will schedule and perform semi-annual audits, verifying that the facility remains in compliance with the requirements of K511.

**5. What is the date of completion?**

All corrective actions were completed 2/19/2019.  
Please accept this as the facility's allegation of compliance.

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## K712 Fire Drills

**1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?**

The facility was found to be missing fire drill documentation on first shift for fourth quarter 2018. This deficiency was identified as affecting all residents, staff, and visitors on the date of the survey. No corrective action can be made to replace the missing documentation. However, the facility will perform an additional make-up drill during the first quarter of 2019. It will be the facility's intention to keep copies of all future records in a manner that will ensure compliance.

**2. How will other residents, having the potential to be affected by the same deficient practice, be identified?**

This deficiency was identified as affecting all residents, staff, and visitors on the date of the survey, and no additional residents should be affected if the facility remains in compliance of keeping fire drill documentation.

**3. What measures will be put into place, or what systemic changes will be made to ensure that the deficient practice does not recur?**

After each fire drill, the environmental services director will keep copies of the supporting documentation in two places: 1) The facility Survey Documentation Binder, and 2) A scanned copy will be uploaded into the Tels maintenance program(a web based service).

**4. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur?**

The facility safety committee will audit the fire drill documentation at each meeting to ensure compliance.

**5. What is the date of completion?**

On 2/18/19 the environmental services director verified that all known fire drill documentation was archived as indicated above(see 3). Please accept this as the facility's allegation of compliance.

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IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

BRAD LITTLE - Governor  
DAVE JEPPESEN - Director

TAMARA PRISOCK - ADMINISTRATOR  
DIVISION OF LICENSING & CERTIFICATION  
DEBRA RANSOM, R.N., R.H.I.T., Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0009  
PHONE 208-334-6626  
FAX 208-364-1888

February 8, 2019

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 30, 2019**, 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 21, 2019**. Failure to submit an acceptable PoC by **February 21, 2019**, may result in the imposition of civil monetary penalties by **March 14, 2019**.

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 **March 6, 2019**, (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 25, 2019**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **March 6, 2019**, includes the following:

Denial of payment for new admissions effective **April 30, 2019**.  
42 CFR §488.417(a)

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

Craig Perez, Administrator

February 7, 2019

Page 3 of 4

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **July 30, 2019**, if substantial compliance is not achieved by that time.

**Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.**

If you believe these deficiencies have been corrected, you may contact Nate Elkins, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, option 3; Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **January 30, 2019**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

Go to the middle of the page to Information Letters section and click on State and select the following:

BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process

2001-10 IDR Request Form

This request must be received by **February 21, 2019**. If your request for informal dispute

Craig Perez, Administrator

February 7, 2019

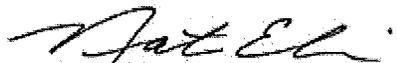
Page 4 of 4

resolution is received after **February 21, 2019**, 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,

A handwritten signature in black ink, appearing to read "Nate Elkins".

Nate Elkins, Supervisor  
Facility Fire Safety and Construction

NE/lj  
Enclosures

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

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NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY - IDAHO FALLS VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 840 EAST ELVA STREET IDAHO FALLS, ID 83401		
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E 000	Initial Comments  The facility is a single story, Type V (111) construction with a partial basement. Original construction was June 1964 with an addition in 1985 and a major renovation in 1995. A new fire alarm/smoke detection system was installed in November 2009. The facility is fully sprinklered with smoke detection coverage throughout the facility including sleeping rooms located in the 1985 addition. Sleeping rooms in the original building do not have smoke detection coverage. The partial basement is a mechanical room with interior and exterior access. The Essential Electrical System is supplied by a diesel powered, on-site automatic generator. The facility is situated in a municipal fire district and is currently licensed for 113 SNF/NF beds with a census of 44 on the dates of the survey.  The following deficiency was cited during the emergency preparedness survey conducted on January 29 - 30, 2019. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73.  The Survey was conducted by:  Linda Chaney Health Facility Surveyor Facility Fire Safety and Construction	E 000	(see attached)		
E 006 SS=F	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2)  [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:]	E 006			

RECEIVED  
FEB 20 2018  
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
*Craig Perez*  
TITLE  
Craig Perez, Administrator  
(X6) DATE  
2/19/2019

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.

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E 006	<p>Continued From page 1</p> <p>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.*</p> <p>*[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents.</p> <p>*[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients.</p> <p>(2) Include strategies for addressing emergency events identified by the risk assessment.</p> <p>* [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to conduct a comprehensive facility-based and community-based risk assessment to include strategies for addressing emergency events identified by the risk assessment. Failure to conduct a facility and community-based risk assessment with strategies for response hinders the facility's ability to respond to localized disasters and emergencies. This deficient practice affected 44 residents, staff and visitors on the dates of the survey.</p>	E 006			

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E 006	Continued From page 2  Findings include:  On January 29, 2019, from approximately 2:00 PM to 4:30 PM, and on January 30, 2019, from approximately 12:00 PM to 12:40 PM, review of the provided emergency preparedness plan, including the facility Hazard Vulnerability Assessment (HVA) revealed some of the hazards identified on the HVA did not have strategies for response. They were; Snowfall, Ice Storm, Generator Failure, Transportation Failure, Natural Gas Failure, Hazmat Exposure - Internal, Supply Shortage, Structural Damage, Mass Casualty - Trauma, Mass Casualty - Medical, Terrorism, VIP Situation, Hostage Situation, Civil Disturbance, Labor Action, Mass Casualty - Hazmat, Small Casualty - Hazmat, Chemical Exposure, and Small/Medium Sized Internal Spill. Additionally, a strategy for response was in the EP plan for threat of Violence/Armed Intruder, but not listed on the HVA. When asked, the Environmental Services Director stated the facility was not aware of the discrepancies on the HVA and thought they had met the requirement.  Reference: 42 CFR 483.73 (a) (1) - (2)	E 006			

*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 7305 of the State Operations Manual.*

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## **E006 Plan Based on All Harzards Risk Assessment**

**1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?**

The center was found to have "failed to conduct a comprehensive facility-based and community-based risk assessment to include strategies for addressing emergency events identified by the risk assessment." To correct this deficiency, the facility administrator and environmental service director reviewed and updated the facility-based risk assessment, ensuring that it took into account not only facility identified risks, but also incorporated and matched risks identified in the community-based risk assessment. After this update, which was completed on 2/14/2019, the facility administrator and environmental service director will ensure that the facility EMP(Emergency Management Plan) includes response strategies for all identified risks.

**2. How will other residents, having the potential to be affected by the same deficient practice, be identified?**

This deficiency was identified as affecting all residents, staff, and visitors on the date of the survey, and no additional residents should be affected.

**3. What measures will be put into place, or what systemic changes will be made to ensure that the deficient practice does not recur?**

When the corrective action is complete, the environmental services director or designee will provide in-service for all facility staff – informing them of the updates to the EMP.

**4. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur?**

The environmental service director will schedule an annual review of the facility risk assessment – to be completed by the facility administrator and environmental service director. All staff members will be informed of any changes to the EMP during the monthly all-staff meeting which follows the annual review.

**5. What is the date of completion?**

The corrective action will be completed by Friday, 3/1/2019.