| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING **02 - ENTIRE STRUCTURE**<br>B. WING _____ | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **135092** | | R<br>**03/12/2020** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **GOOD SAMARITAN SOCIETY - IDAHO FALLS VILLAGE** | **840 EAST ELVA STREET**<br>**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 |
|---|---|---|---|---|
| {K 000} | INITIAL COMMENTS<br><br>On 3/12/20 an off-site follow-up survey was conducted, substantiating compliance for deficiencies identified during the annual Fire/Life Safety survey conducted on 1/23/20. Good Samaritan Society - Idaho Falls Village was determined to be in substantial compliance with all Life Safety Code standards at this time.<br><br>The surveyor completing this survey was:<br><br>Sam Burbank<br>Health Facility Surveyor<br>Facility Fire/Safety and Construction | {K 000} | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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.

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

PRINTED: 03/12/2020
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OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____ | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 135092 | | R 03/12/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY - IDAHO FALLS VILLAGE | 840 EAST ELVA STREET<br>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 |
|---|---|---|---|---|
| {E 000} | Initial Comments<br><br>On 3/12/20 an off-site follow-up survey was conducted, substantiating compliance for deficiencies identified during the Emergency Preparedness survey conducted on 1/23/20. Good Samaritan Society - Idaho Falls Village was determined to be in substantial compliance with all Emergency Preparedness standards at this time.<br><br>The surveyor completing this survey was:<br><br>Sam Burbank<br>Health Facility Surveyor<br>Facility Fire/Safety and Construction | {E 000} | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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