



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

September 1, 2020

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

Provider #: 135067

**RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT
COVER LETTER**

Dear Ms. Berg:

On **August 19, 2020**, a Facility Fire Safety and Construction survey was conducted at **Good Samaritan Society - Moscow 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.

Jamie Berg, Administrator
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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 **September 14, 2020**. Failure to submit an acceptable PoC by **September 14, 2020**, may result in the imposition of civil monetary penalties by **October 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 **September 23, 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 **November 17, 2020**. A change in the seriousness of the deficiencies on **October 3, 2020**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **September 23, 2020**, includes the following:

Denial of payment for new admissions effective **November 19, 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 **February 19, 2021**, 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 **August 19, 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:

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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:

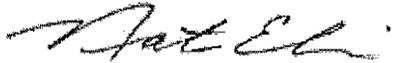
BFS Letters (06/30/11)

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

This request must be received by **September 14, 2020**. If your request for informal dispute resolution is received after **September 14, 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

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

Printed: 08/28/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135067	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 08/19/2020
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - MOSCOW VILL	STREET ADDRESS, CITY, STATE, ZIP CODE 640 NORTH EISENHOWER STREET MOSCOW, ID 83843
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	<p>INITIAL COMMENTS</p> <p>The facility is a single story, Type II (111) structure originally constructed in 1975. There is a two-hour horizontal separation from the Independent/Assisted Living apartment complex. The facility is fully sprinklered, with an interconnected fire alarm/smoke detection system. Backup emergency power is provided by an on-site, spark-ignited Emergency Power Supply System (EPSS) generator set. Currently, the facility is licensed for 63 SNF/NF beds, and had a census of 43 on the date of the survey.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on August 19, 2020. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.</p> <p>The Survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	K 000	<p>Preparation and Execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations manual.</p> <p>K 325 SS=D</p> <ol style="list-style-type: none"> a. An ABHR logbook will be created with specific actions to be taken during the refilling/replacing process. b. The dispenser outside room 204 directly over the outlet was removed. 	
K 325 SS=D	<p>Alcohol Based Hand Rub Dispenser (ABHR) CFR(s): NFPA 101</p> <p>Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met:</p> <ul style="list-style-type: none"> * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, 	K 325	<ol style="list-style-type: none"> All the residents have the potential to be affected. All dispensers will be inspected and audited to ensure functionality and appropriate placement. Housekeeping employees will be educated on the logbook and the requirements. Maintenance employees will be educated on the placement of ABHR dispensers. The Maintenance Director or designee will audit the ABHR logbook weekly x 4 and monthly x 2. Dispenser placement will be audited monthly x 3. All audit findings will be reported to 	9/23/2020

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Jamie Bee</i>	TITLE <i>Administrator</i>	(X6) DATE <i>9/11/2020</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 325	<p>Continued From page 1</p> <p>excluding one individual dispenser per room</p> <ul style="list-style-type: none"> * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and observation, the facility failed to ensure installations for alcohol-based hand rub (ABHR) dispensers, was in accordance with NFPA 101. Failure to ensure the fire safety precautions for ABHR dispensers are followed, has the potential for increased risk of fires due to flammable liquids. This deficient practice affected 14 residents in the 200 hall and those areas of the facility where automatic or manual dispensers of ABHR are installed.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1) During review of provided ABHR logs conducted on 8/19/2020 from 2:30 - 3:00 PM, logs indicated a date and initials of staff replacing the refill but did not demonstrate what actions, inspections, or testing was conducted during the replacement or refilling process. 2) During the facility tour conducted on 8/19/2020 from 1:00 - 3:00 PM, observation of the ABHR dispensers installed in the facility revealed predominantly manually-activated dispensers. Further observation revealed the 	K 325	<p>QA/CQI for further monitoring and modification.</p> <p>5. Corrective action will be completed on or before September 23, 2020.</p>	
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K 325	<p>Continued From page 2</p> <p>manually-activated dispenser installed outside room 204 revealed the dispenser was installed directly over the electrical outlet.</p> <p>Actual NFPA standard:</p> <p>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:</p> <p>(1) Where dispensers are installed in a corridor, the corridor shall have a minimum width of 6 ft (1830 mm).</p> <p>(2) The maximum individual dispenser fluid capacity shall be as follows:</p> <p>(a) 0.32 gal (1.2 L) for dispensers in rooms, corridors, and areas open to corridors</p> <p>(b) 0.53 gal (2.0 L) for dispensers in suites of rooms</p> <p>(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.</p> <p>(4) Dispensers shall be separated from each other by horizontal spacing of not less than 48 in. (1220 mm).</p> <p>(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 to exceed, 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).</p> <p>(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).</p> <p>(7) Storage of quantities greater than 5 gal (18.9</p>	K 325		
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K 325	<p>Continued From page 3</p> <p>L) in a single smoke compartment shall meet the requirements of NFPA 30, Flammable and Combustible Liquids Code.</p> <p>(8) Dispensers shall not be installed in the following locations:</p> <p>(a) Above an ignition source within a 1 in. (25 mm) horizontal distance from each side of the ignition source</p> <p>(b) To the side of an ignition source within a 1 in. (25mm) horizontal distance from the ignition source</p> <p>(c) Beneath an ignition source within a 1 in. (25 mm) vertical distance from the ignition source</p> <p>(9) Dispensers installed directly over carpeted floors shall be permitted only in sprinklered smoke compartments.</p> <p>(10) The alcohol-based hand-rub solution shall not exceed 95 percent alcohol content by volume.</p> <p>(11) Operation of the dispenser shall comply with the following criteria:</p> <p>(a) The dispenser shall not release its contents except when the dispenser is activated, either manually or automatically by touch-free activation.</p> <p>(b) Any activation of the dispenser shall occur only when an object is placed within 4 in. (100 mm) of the sensing device.</p> <p>(c) An object placed within the activation zone and left in place shall not cause more than one activation.</p> <p>(d) The dispenser shall not dispense more solution than the amount required for hand hygiene consistent with label instructions.</p> <p>(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.</p> <p>(f) The dispenser shall be tested in accordance with the manufacturer ' s care and use instructions each time a new refill is installed.</p>	K 325		

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K 353 K 353 SS=F	Continued From page 4 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, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked b) Who provided system test c) Water system supply source 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 record review, the facility failed to ensure fire suppression systems were maintained in accordance with NFPA 25. Failure to perform quarterly waterflow alarm system testing, along with required dry system inspection and testing has the potential to hinder system response during a fire event. This deficient practice affected 43 residents, staff and visitors on the date of the survey. Findings include: During review of provided fire suppression system maintenance and testing records conducted on 8/19/2020 from 8:30 - 10:45 AM, records were not available for 3 of 4 quarters on	K 353 K 353	K 353 SS=F 1. Quarterly testing of the waterflow alarm system will be completed and the 10-year dry sprinklers will be tested 10/8/2020. 2. All residents have the potential to be affected. 3. A preventive maintenance plan will be developed to test the waterflow alarm system quarterly and test/replace the dry sprinklers every 10 years. 4. The Maintenance Director or designee will audit the testing quarterly x 3. All audit findings will be reported to QA/CQI for further monitoring and modification. 5. Corrective action will be completed on or before September 23, 2020 October 8, 2020	9/23/2020 10/8/2020

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K 353	Continued From page 5 waterflow alarm motor gong testing or a ten-year testing or replacement of the installed dry sprinklers. Actual NFPA standard: 5.3.1.1.1.6* Dry sprinklers that have been in service for 10 years shall be replaced or representative samples shall be tested and then retested at 10-year intervals. 13.2.6 Alarm Devices. 13.2.6.1 Mechanical waterflow devices, including but not limited to water motor gongs, shall be tested quarterly.	K 353		
K 511 SS=D	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 safe electrical installations in accordance with NFPA 70. Placing extension cords under walking surfaces and use as connected in series, has the potential for arc fires and electric shock. This deficient practice affected staff on the date of the survey.	K 511	K 511 SS=D 1. a. The extension cord under the walking surface has been removed. b. The RTP in the conference room has been removed. 2. All employees in the mechanical room or conference room have the potential to be affected. An audit will be completed to identify additional RTPs or extension cords under walking surfaces. 3. Employees will be educated on the use of RTPs and extension cords under surfaces. 4. The Maintenance Director or designee will audit for RTPs or extension cords under surfaces monthly x 3. All audit findings will be reported to QA/CQI for further monitoring and modification. 5. Corrective action will be completed on or before September 23, 2020.	9/23/2020

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K 511	<p>Continued From page 6</p> <p>Findings include:</p> <p>During the facility tour conducted on 8/19/2020 from 1:00 - 3:00 PM, observation of installed electrical systems revealed the following:</p> <p>1) In the room housing the main generator, the EPSS was observed to be using an extension cord ran underneath a carpet in front of the exit door to supply power to the battery charger on the system.</p> <p>2) In the main conference room, the relocatable power tap (RPT) on top of the conference room table was observed to be connected in series (daisy-chained) to an extension cord.</p> <p>Actual NFPA standard:</p> <p>NFPA 70</p> <p>110.3 Examination, Identification, Installation, and Use of Equipment.</p> <p>(A) Examination. In judging equipment, considerations such as the following shall be evaluated:</p> <p>(1) Suitability for installation and use in conformity with the provisions of this Code</p> <p>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.</p>	K 511		

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K 511	<p>Continued From page 7</p> <p>(2) Mechanical strength and durability, including, for parts designed to enclose and protect other equipment, the adequacy of the protection thus provided</p> <p>(3) Wire-bending and connection space</p> <p>(4) Electrical insulation</p> <p>(5) Heating effects under normal conditions of use and also under abnormal conditions likely to arise in service</p> <p>(6) Arcing effects</p> <p>(7) Classification by type, size, voltage, current capacity, and specific use</p> <p>(8) Other factors that contribute to the practical safeguarding of persons using or likely to come in contact with the equipment</p> <p>(B) Installation and Use. Listed or labeled equipment shall be installed and used in accordance with any instructions included in the listing or labeling.</p> <p>400.8 Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following:</p> <p>(1) As a substitute for the fixed wiring of a structure</p> <p>(2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors</p> <p>(3) Where run through doorways, windows, or similar openings</p> <p>(4) Where attached to building surfaces 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)</p> <p>(5) Where concealed by walls, floors, or ceilings or located above suspended or dropped ceilings</p> <p>(6) Where installed in raceways, except as otherwise permitted in this Code</p> <p>(7) Where subject to physical damage</p>	K 511		

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

Printed: 08/28/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135067	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 08/19/2020
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - MOSCOW VILL	STREET ADDRESS, CITY, STATE, ZIP CODE 640 NORTH EISENHOWER STREET MOSCOW, ID 83843
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K 511	Continued From page 8	K 511		
K 522 SS=E	<p>Additional reference: UL 1363 XYBS</p> <p>HVAC - Any Heating Device CFR(s): NFPA 101</p> <p>HVAC - Any Heating Device Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: * is chimney or vent connected. * takes air for combustion from outside. * provides for a combustion system separate from occupied area atmosphere. 19.5.2.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that heating devices were maintained with clearance from combustible sources. Failure to keep combustible items such as furniture and storage away from baseboard heating systems, has been historically linked to facility fires. This deficient practices affected staff and visitors of the main dining hall on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 8/19/2020 from 1:00 - 3:00 PM, observation of the main dining hall revealed four (4) of the installed electric wall heating devices had furniture stored directly abutting and against the exhaust surface. Further observation noted the items placed against the heaters as two (2) wooden chairs and two (2) wooden dining tables.</p>	K 522	<p>K 522 SS=E</p> <ol style="list-style-type: none"> 1. Furniture in the dining room was moved away from the electric wall heating devices per manufacturer's guidelines. 2. All residents have the potential to be affected. 3. Dietary, housekeeping and maintenance employees will be educated on keeping furniture from directly abutting or against the baseboard heater exhaust surface. 4. The Dietary Director or designee will audit the dining room furniture placement weekly x 4 and monthly x 1. All audit findings will be reported to QA/CQI for further monitoring and modification. 5. Corrective action will be completed on or before September 23, 2020. 	9/23/2020

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - MOSCOW VILL		STREET ADDRESS, CITY, STATE, ZIP CODE 640 NORTH EISENHOWER STREET MOSCOW, ID 83843		
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K 522	<p>Continued From page 9</p> <p>When asked at the time of the observation about this observation, the Maintenance Supervisor stated that staff had apparently moved the furnishings up against the wall units to provide spacing for resident dining and avoid cohorting during the ongoing pandemic crisis.</p> <p>Actual NFPA standard:</p> <p>19.5.2 Heating, Ventilating, and Air-Conditioning. 19.5.2.1 Heating, ventilating, and air-conditioning shall comply with the provisions of Section 9.2 and shall be installed in accordance with the manufacturer ' s specifications, unless otherwise modified by 19.5.2.2. 19.5.2.2* Any heating device, other than a central heating plant, shall be designed and installed so that combustible material cannot be ignited by the device or its appurtenances, and the following requirements also shall apply: (1) If fuel-fired, such heating devices shall comply with the following: (a) They shall be chimney connected or vent connected. (b) They shall take air for combustion directly from the outside. (c) They shall be designed and installed to provide for complete separation of the combustion system from the atmosphere of the occupied area. (2) Any heating device shall have safety features to immediately stop the flow of fuel and shut down the equipment in case of either excessive temperature or ignition failure.</p>	K 522		

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - MOSCOW VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 640 NORTH EISENHOWER STREET MOSCOW, ID 83843		
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C 000	<p>INITIAL COMMENTS</p> <p>The facility is a single story, Type II (111) structure originally constructed in 1975. There is a two-hour horizontal separation from the Independent/Assisted Living apartment complex. The facility is fully sprinklered, with an interconnected fire alarm/smoke detection system. Backup emergency power is provided by an on-site, spark-ignited Emergency Power Supply System (EPSS) generator set. Currently, the facility is licensed for 63 SNF/NF beds, and had a census of 43 on the date of the survey.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on August 19, 2020. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy in accordance with 42 CFR 483.70 and IDAPA 16.03.02, Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities.</p> <p>The Survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	C 000	<p>Preparation and Execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations manual.</p> <p>SEP 14 2020</p> <p>C 431 FACILITY STANDARDS</p>	
C 431	<p>02.120,10 Electrical and Lighting Standards</p> <p>10. Electrical and Lighting. All electrical and lighting installation shall be in accordance with the National Electrical Code (1984 ed.) and as follows:</p> <p>This RULE: is not met as evidenced by: Based on observation and interview, the facility failed to ensure power to electrical equipment and appliances was not provided using multiple plug</p>	C 431	<p>1. The MPA was removed from room 302 and the printer in medical records.</p> <p>2. All residents using a MPA have the potential to be affected.</p> <p>3. Maintenance employees will be educated on the use of MPAs in the facility. An audit will be completed to identify additional MPAs.</p> <p>4. The Maintenance Director or designee will audit for MPAs weekly x 4 and monthly x 1. All audit findings will be reported to QA/CQI for further monitoring and modification.</p> <p>5. Corrective action will be completed on or before September 23, 2020</p>	9-23-2020

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

TITLE

(X6) DATE

STATE FORM

021109

2D1M21

If continuation sheet 1 of 2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135067	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED 08/19/2020
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C 431	<p>Continued From Page 1</p> <p>adapters. The use of multiple plug adapters (MPA) has been historically linked to arc fires in facilities. This deficient practice affected 6 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 8/19/2020 from 1:00 - 3:00 PM, observation of installed electrical systems revealed the use of a multiple plug adapter to supply power to a television in resident room 302 and the data matrix printer in the Medical Records office. When asked at the time of the observations as to why these areas were using a MPA for supplying power from the outlet, the Maintenance Supervisor stated the facility was not aware these applications were not permitted.</p> <p>Actual IDAPA reference:</p> <p>IDAPA 16.03.02.120.10(c)</p> <p>c. Plug adaptors and multiple outlets are prohibited.</p>	C 431			

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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

September 1, 2020

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

Provider #: 135067

RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER

Dear Ms. Berg:

On **August 19, 2020**, an Emergency Preparedness survey was conducted at Good Samaritan Society - Moscow Village by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. Your facility was found to be in substantial compliance with Federal regulations during this survey.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, which states that the facility complies with the requirements of CFR 42, 483.70(a) of the federal requirements. This form is for your records only and does not need to be returned.

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

Sincerely,

Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj

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

Printed: 08/28/2020
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E 000	<p>Initial Comments</p> <p>The facility is a single story, Type II (111) structure originally constructed in 1975. The building is located within a municipal fire district with both state and federal EMS services available. There is a two-hour horizontal separation from the Independent/Assisted Living apartment complex. The facility is fully sprinklered, with an interconnected fire alarm/smoke detection system. Backup emergency power is provided by an on-site, spark-ignited Emergency Power Supply System (EPSS) generator set. Currently, the facility is licensed for 63 SNF/NF beds, and had a census of 43 on the date of the survey.</p> <p>The facility was found to be in substantial compliance during the annual Emergency Preparedness Survey conducted on August 19, 2020. The facility was surveyed under the Emergency Preparedness Rule in accordance with 42 CFR 483.73.</p> <p>The Survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	E 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.