STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135136

(X2) MULTIPLE CONSTRUCTION
A. BUILDING _____________________________
B. WING _____________________________

(X3) DATE SURVEY COMPLETED
09/14/2017

NAME OF PROVIDER OR SUPPLIER
QUINN MEADOWS REHABILITATION & CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
1033 WEST QUINN ROAD
POCATELLO, ID 83202

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

(F 000) INITIAL COMMENTS
Follow-up survey was conducted on September 13, 2017 and September 14, 2017, and it was determined the facility was back in substantial compliance as of the date alleged in their plan of correction.

The surveyors conducting the survey were Linda Kelly, R.N., and Jenny Walker, R.N.

Electronicallly Signed
09/15/2017

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

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.