September 21, 2018

Monica Brutsman, Administrator
The Terraces of Boise
5301 E. Warm Springs Ave.
Boise, ID 83716

Provider #: 135141

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Ms. Brutsman:

On September 14, 2018, a Facility Fire Safety and Construction survey was conducted at The Terraces of Boise 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 **October 4, 2018.** Failure to submit an acceptable PoC by **October 4, 2018,** may result in the imposition of civil monetary penalties by **October 26, 2018.**

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 **October 19, 2018, (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 **October 19, 2018.** A change in the seriousness of the deficiencies on **October 19, 2018,** may result in a change in the remedy.
The remedy, which will be recommended if substantial compliance has not been achieved by October 19, 2018, includes the following:

Denial of payment for new admissions effective December 14, 2018.

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 March 14, 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 September 14, 2018, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

BFS Letters (06/30/11)

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

This request must be received by October 4, 2018. If your request for informal dispute resolution is received after October 4, 2018, 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/iJ
Enclosures
**Statement of Deficiencies and Plan of Correction**

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<th>Provider/Supplier/CUA Identification Number:</th>
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**Name of Provider or Supplier:**

**Terraces of Boise, The**

**Street Address, City, State, Zip Code:**

5301 E Warm Springs Ave

Boise, ID 83716

**Summary Statement of Deficiencies**

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

- **K 000**
  - **Initial Comments**
    - The Facility consists of three (3), single story buildings (J,K,L), Type V (III) construction. The buildings are approximately 12,465 square feet, each with 16 single occupancy resident rooms. Each building is divided into two smoke compartments with fire dampers throughout. Buildings are fully sprinklered with both wet and dry systems and have quick response sprinkler heads throughout. Each building is equipped with a manual fire alarm system with corridor smoke detection and is electronically monitored off-site. The Essential Electrical System is supplied by a diesel powered, on-site automatic generator. Currently the facility is licensed for 48 SNF/NF beds (16 each building), and had a census of 29 on the dates of the survey.

  - The following deficiencies were cited during the annual life safety code survey conducted on September 13 - 14, 2018. The facility was surveyed under the Life Safety Code, 2012 Edition, Chapter 19, Existing Healthcare Occupancies, 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 & Construction

  - **K 100**
    - **General Requirements - Other**
      - CFR(s): NFPA 101
    - **General Requirements - Other**
      - List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are

**Provider's Plan of Correction**

Each corrective action should be cross-referenced to the appropriate deficiency.

- **K 100**
  - **Water management plan**
    1. By 10/3/18 water testing for legionella and chlorine will be completed for all healthcare areas, to ensure no legionella is identified and chlorine with within acceptable ranges.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**
TERRACES OF BOISE, THE

**STREET ADDRESS, CITY, STATE, ZIP CODE**
5301 E WARM SPRINGS AVE
BOISE, ID 83716

**ID NUMBER**: 135141

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**SUMMARY STATEMENT OF DEFICIENCIES**

**K 100 Continued From page 1**

**2. Residents residing in the facilities have the potential to be affected.** By 10/3/18 water testing for legionella and chlorine will be completed for all healthcare areas, to ensure no legionella is identified and chlorine was within acceptable ranges.

**3. By 10-3-18, facility water management plan and Policy and Procedures, were revised and updated to include current facility risks, control measures, and testing protocols.** Water flow charting with water source mapping was completed and added to the water management plan. Testing protocols revised and include random water delivery source testing quarterly. Control measures revised to include parameters for results of water tests, and procedure for testing water.

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**ID**

**PREFIX**

**TAG**

**K 100**

**ID**

**PREFIX**

**TAG**

**K 100**

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**COMPLETION DATE**

**09/14/2018**
K 100 Continued From page 2

Additional Reference:

K 291 Emergency Lighting

Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9, 18.2.9.1, 19.2.9.1

This REQUIREMENT is not met as evidenced by:
Based on record review and interview the facility failed to provide annual emergency lighting test documentation. Failure to test the emergency lighting could inhibit egress of residents during an emergency. This deficient practice affected 29 residents, staff and visitors on the day of survey.

Findings include:
During review of the facility emergency lighting test logs on September 13, 2018, from approximately 8:30 AM to 2:30 PM, no documentation could be produced for a 90-minute test of the emergency lighting in the past 12 months. When asked, the Physical Facilities Director stated the facility was unaware the test was required.

Actual NFPA reference:
NFPA 101
19.2.9 Emergency Lighting.
19.2.9.1 Emergency lighting shall be provided in accordance with Section 7.9.
7.9.3 Periodic Testing of Emergency Lighting

4. Starting 10-3-18, Physical Facilities Director will complete 10 random water tests at the delivery spot to the residents, quarterly. Results of the random water tests will be reported in the Monthly Quality Assurance Performance Improvement meeting.

Preventative Maintenance Calendar will include a semi annual reminder and requirement to test all water sources to the Healthcare Facilities.

5. Corrective Date 10/3/18.

K 291- Emergency lighting

1. The emergency lighting test was performed, by the maintenance staff, and documented for a duration of 1 ½ hours, on 9/29/18, no concerns were noted.
### Equipment

7.9.3.1 Required emergency lighting systems shall be tested in accordance with one of the three options offered by 7.9.3.1.1, 7.9.3.1.2, or 7.9.3.1.3.

7.9.3.1.1 Testing of required emergency lighting systems shall be permitted to be conducted as follows:

1. Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, except as otherwise permitted by 7.9.3.1.1(2).

2. The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having jurisdiction.

3. Functional testing shall be conducted annually for a minimum of 1-1/2 hours if the emergency lighting system is battery powered.

4. The emergency lighting equipment shall be fully operational for the duration of the tests required by 7.9.3.1.1(1) and (3).

5. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction.

7.9.3.1.2 Testing of required emergency lighting systems shall be permitted to be conducted as follows:

1. Self-testing/self-diagnostic battery-operated emergency lighting equipment shall be provided.

#### K 325 Alcohol Based Hand Rub Dispenser (ABHR)

- All current dispensers were tested, and operated correctly, by Housekeeping Director on 9/27/18

#### K 291

- All residents residing in the facility have the potential to be affected. Above testing was done for all healthcare locations.

- Physical Facilities Director will complete and document the required testing for 90 minutes, annually going forward. This test was added to the schedule of tasks to be completed by maintenance department.

- Physical Facilities Director will report the completion of the yearly test in the Monthly Safety Meeting.

- Corrective Date 10/3/18
K 325 Continued From page 4
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,
excluding one individual dispenser per room
* 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
This REQUIREMENT is not met as evidenced
by:
Based on record review, observation and
interview, the facility failed to ensure Alcohol
Based Hand Rub Dispensers (ABHR) were
maintained in accordance with NFPA 101. Failure
to test and document the operation of ABHR
dispensers in accordance with the manufacturer's
care and use instructions each time a new refill is
installed could result in inadvertently spilling
flammable liquids, increasing the risk of fires.
This deficient practice affected 29 residents, staff
and visitors on the date of the survey.

Findings include:
During the review of facility inspection records on
September 13, 2018, from approximately 8:30
AM to 2:30 PM, no records were available

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| K 325 | | 2. Residents residing in the
facility were (ABHR)
dispensers are used, have
the potential to be affected.
Dispensers in the facility
were inspected and tested
on 9/27/18 and they were
working according to the
manufacturer's guidelines.
On 9/27/18, Housekeeping
Director re in-serviced
housekeeping staff on
manufacturers guidelines,
testing dispenser when
refilling, and documenting
such inspections at time of
refill.
3. Each (ABHR) dispenser was
numbered and guidelines
from the manufacturer were
laminated and placed in
each dispenser, for easy
reference by staff. | |

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| (X2) MULTIPLE CONSTRUCTION |
| A. BUILDING 01 - TERRACES OF BOISE-MAPLE COTTAGE |
| B. WING |

| (X1) PROVIDER/SUPPLIER/CLIA |
| IDENTIFICATION NUMBER |
| 135141 |

| NAME OF PROVIDER OR SUPPLIER |
| TERRACES OF BOISE, THE |

| STREET ADDRESS, CITY, STATE, ZIP CODE |
| 5301 E WARM SPRINGS AVE |
| BOISE, ID 83716 |

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

| PROVIDER'S PLAN OF CORRECTION |
| EACH CORRECTIVE ACTION SHOULD BE |
| CROSS-REFERENCED TO THE APPROPRIATE |
| DEFICIENCY |
indicating ABHR dispensers were tested in accordance with manufacturer's care and use instructions when a new refill is installed. ABHR dispensers were observed throughout the facility and when asked, the Physical Facilities Director stated the facility was not aware of the requirement to test ABHR dispensers each time a new refill is installed.

Actual NFPA standard:

NFPA 101

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:

(1) Where dispensers are installed in a corridor, the corridor shall have a minimum width of 6 ft (1830 mm).

(2) The maximum individual dispenser fluid capacity shall be as follows:

(a) 0.32 gal (1.2 L) for dispensers in rooms, corridors, and areas open to corridors

(b) 0.53 gal (2.0 L) for dispensers in suites of rooms

(3) Where aerosol containers are used, the maximum capacity of the aerosol dispenser shall be 18 oz. (0.51 kg) and shall be limited to Level 1 aerosols as defined in NFPA30B, Code for the Manufacture and Storage of Aerosol Products.

(4) Dispensers shall be separated from each other by horizontal spacing of not less than 48 in. (1220 mm).

(5) Not more than an aggregate 10 gal (37.8 L) of alcohol-based hand-rub solution or 1135 oz (32.2 kg) of Level 1 aerosols, or a combination of liquids and Level 1 aerosols not to exceed, in total, the equivalent of 10 gal (37.8 L) or 1135 oz.

K 325 Documentation cards were revised to include the date, dispenser #, inspection of dispenser, batteries tested, and staff initial. Documentation cards will be completed for each dispenser when the alcohol based hand rub is refilled/replaced.

4. Monthly the Housekeeping Director will complete random audits of the dispensers to ensure that they are functioning properly, and that the documentation at the time of the refill is completed. Results of random audits will be reported to the Monthly Quality Assurance and Performance Improvement committee for review.

5. Corrective date 10/3/18
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(32.2 kg), shall be in use outside of a storage cabinet in a single smoke compartment, except as otherwise provided in 19.3.2.6(6).

(6) One dispenser complying with 19.3.2.6 (2) or (3) per room and located in that room shall not be included in the aggregated quantity addressed in 19.3.2.6(5).

(7) Storage of quantities greater than 5 gal (18.9 L) in a single smoke compartment shall meet the requirements of NFPA 30, Flammable and Combustible Liquids Code.

(8) Dispensers shall not be installed in the following locations:
   (a) Above an ignition source within a 1 in. (25 mm) horizontal distance from each side of the ignition source
   (b) To the side of an ignition source within a 1 in. (25 mm) horizontal distance from the ignition source
   (c) Beneath an ignition source within a 1 in. (25 mm) vertical distance from the ignition source

(9) Dispensers installed directly over carpeted floors shall be permitted only in sprinklered smoke compartments.

(10) The alcohol-based hand-rub solution shall not exceed 95 percent alcohol content by volume.

(11) Operation of the dispenser shall comply with the following criteria:
   (a) The dispenser shall not release its contents except when the dispenser is activated, either manually or automatically by touch-free activation.
   (b) Any activation of the dispenser shall occur only when an object is placed within 4 in. (100 mm) of the sensing device.
   (c) An object placed within the activation zone and left in place shall not cause more than one activation.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

**NAME OF PROVIDER OR SUPPLIER**

TERRACES OF BOISE, THE

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

5301 E WARM SPRINGS AVE
BOISE, ID 83716

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<td>(d) The dispenser shall not dispense more solution than the amount required for hand hygiene consistent with label instructions. (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. (f) The dispenser shall be tested in accordance with the manufacturer's care and use instructions each time a new refill is installed.</td>
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| K 712               | 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.
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 required fire drills, one per shift per quarter. 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 29 residents, staff and visitors on the date of the survey.

Findings include:

K 712- Fire Drill documentation

1. Starting 9/28/18- Fire Drills will be completed and documented one per shift per quarter.
2. Residents residing in the facility have the potential to be affected, drills will be completed monthly and alternate between the Day, Pm, and Night shifts.
3. On 9.28.18, the Physical Facilities Director was re-in-serviced by the Administrator on the fire drill requirements. Fire drill documentation sheet will have clear documentation of which shift the drill is performed on.
K712

During record review September 13, 2018, from approximately 8:30 AM to 2:30 PM, fire drill documentation revealed the facility failed to perform fire drills for first shift, first quarter 2018; third shift, second quarter 2018; and first shift, fourth quarter 2017. When asked, the Physical Facilities Director stated the facility had accidentally completed drills on shifts that had already been done and was unaware of the missing fire drills.

Actual NFPA standard:

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.

K712

4. Physical Facilities Director will report on Fire Drills completed in the last 30 days, to the Safety committee monthly.

5. Corrective Date- 10/3/18
September 21, 2018

Monica Brutsman, Administrator
The Terraces of Boise
5301 E. Warm Springs Ave.
Boise, ID 83716

Provider #: 135141

RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER

Dear Ms. Brutsman:

On September 14, 2018, an Emergency Preparedness survey was conducted at The Terraces of Boise 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

Enclosures
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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TERRACES OF BOISE, THE

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

5301 E WARM SPRINGS AVE
BOISE, ID 83716

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**SUMMARY STATEMENT OF DEFICIENCIES**

**E 000** Initial Comments

The Facility consists of three (3), single story buildings (J,K,L), Type V (III) construction. The buildings are approximately 12,465 square feet, each with 16 single occupancy resident rooms. Each building is divided into two smoke compartments with fire dampers throughout. Buildings are fully sprinklered with both wet and dry systems and have quick response sprinkler heads throughout. Each building is equipped with a manual fire alarm system with corridor smoke detection and is electronically monitored off-site. The Essential Electrical System is supplied by a diesel powered, on-site automatic generator. Currently the facility is licensed for 48 SNF/NF beds (16 each building), and had a census of 29 on the dates of the survey.

The facility was found to be in substantial compliance during the initial Emergency Preparedness Survey conducted on September 13 - 14, 2018. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 C.F.R 483.73.

The Survey was conducted by:

Linda Chaney
Health Facility Surveyor
Facility Fire Safety & Construction

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

**TITLE**

**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.