



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

C.L. "BUTCH" OTTER – Governor  
RICHARD M. ARMSTRONG – Director

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

**CERTIFIED MAIL: 7012 1010 0002 0836 3943**

September 17, 2013

Tiffany Goin, Administrator  
Life Care Center of Lewiston  
325 Warner Drive  
Lewiston, ID 83501

Provider #: 135128

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

Dear Ms. Goin:

On **September 11, 2013**, a Facility Fire Safety and Construction survey was conducted at **Life Care Center of Lewiston** 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 and a similar State Form 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

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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 both Statement of Deficiencies and Plan of Correction, Form CMS-2567 and State Form, in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **September 30, 2013**. Failure to submit an acceptable PoC by **September 30, 2013**, may result in the imposition of civil monetary penalties by **October 20, 2013**.

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.

All references to federal regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **October 16, 2013**, (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 16, 2013**. A change in the seriousness of the deficiencies on **October 16, 2013**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **October 16, 2013**, includes the following:

Denial of payment for new admissions effective **December 11, 2013**.

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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 11, 2014**, 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 Mark P. Grimes, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, 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 11, 2013**, 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

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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 30, 2013**. If your request for informal dispute resolution is received after **September 30, 2013**, 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.

Sincerely,

A handwritten signature in black ink, appearing to read 'Mark P. Grimes', with a long horizontal flourish extending to the right.

Mark P. Grimes, Supervisor  
Facility Fire Safety and Construction

MPG/lj  
Enclosures

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

Printed: 09/16/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135128</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02 - ENTIRE BUILDING</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/11/2013</b>
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NAME OF PROVIDER OR SUPPLIER <b>LIFE CARE CENTER OF LEWISTON</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>325 WARNER DRIVE LEWISTON, ID 83501</b>
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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
K 000	<p><b>INITIAL COMMENTS</b></p> <p>The facility is a 55,000 square foot single story type V(111) building constructed in 1997. It is fully sprinklered and has smoke detection throughout. Currently the facility is licensed for 121 SNF/NF beds.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on September 11, 2013. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.</p> <p>The Survey was conducted by:</p> <p>Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction</p>	K 000	<p>This plan of correction is submitted as required under Federal and State regulations and statutes applicable to long term care providers. This plan of correction does not constitute an admission of liability on the part of the facility and, such liability is hereby specifically denied. The submission of the plan does not constitute agreement by the facility that the surveyor's findings and/or conclusions are accurate, that the findings constitute a deficiency or that the scope and severity regarding any of the deficiencies cited are correctly applied.</p>	10/10/13
K 046 SS=D	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.</p> <p>This Standard is not met as evidenced by: Based on observation and operational testing it was revealed that the facility did not ensure that emergency lighting was being maintained in an operational status. This deficiency can leave an area in darkness in the event of a power outage. The facility had a census of eighty nine residents on the day of survey. This deficiency affected no residents and four staff member in one of seven smoke compartments.</p> <p>Findings include:</p> <p>During a tour of the facility on September 11,</p>	K 046	<p><b>RECEIVED</b> <b>OCT - 1 2013</b> <b>FACILITY STANDARDS</b></p> <p><b>SPECIFIC RESIDENTS</b> No residents were directly affected by this practice</p> <p><b>OTHER RESIDENTS</b> All residents are at risk from this deficient practice.</p>	10/10/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Gregory A. Bolan TITLE: Interim Executive Director (X6) DATE: 09-27-13

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

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NAME OF PROVIDER OR SUPPLIER <b>LIFE CARE CENTER OF LEWISTON</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>325 WARNER DRIVE LEWISTON, ID 83501</b>		
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K 046	Continued From page 1 2013 at 1:15 PM, observation of operational testing of the emergency lighting unit located in the laundry room revealed that the light would not illuminate upon pressing the test button. This was observed and noted by the Surveyor and Maintenance Supervisor.  Actual NFPA Standard:  19.2.9.1 Emergency lighting shall be provided in accordance with Section 7.9.  7.9.2.1* Emergency illumination shall be provided for not less than 1 1/2 hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10 lux) and, at any point, not less than 0.1 ft-candle (1 lux), measured along the path of egress at floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candle (6 lux) and, at any point, not less than 0.06 ft-candle (0.6 lux) at the end of the 1 1/2 hours. A maximum-to-minimum illumination uniformity ratio of 40 to 1 shall not be exceeded.  7.9.2.2* The emergency lighting system shall be arranged to provide the required illumination automatically in the event of any of the following: (1) Interruption of normal lighting such as any failure of a public utility or other outside electrical power supply (2) Opening of a circuit breaker or fuse (3) Manual act(s), including accidental opening of a switch controlling normal lighting facilities	K 046	<b>SYSTEMATIC CHANGES</b> Lighting system unit that failed has been replaced. All lighting system units have been checked to assure they are operational. Lighting system units will be checked by maintenance director or maint assistant weekly to ensure they are operational.  <b>MONITOR</b> Maintenance director will audit monthly, the lighting system units to ensure they have been checked weekly and that the batteries are scheduled and changed on an annual basis. Audits will be reviewed montly in PI meeting to monitor the system and ensure compliance.	10/10/13
K 069 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Cooking facilities are protected in accordance	K 069		

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K 069	<p>Continued From page 2 with 9.2.3. 19.3.2.6, NFPA 96</p> <p>This Standard is not met as evidenced by: Based on record review and staff interview it was determined that the facility did not ensure that the kitchen hood was being maintained in accordance with NFPA 96. Maintaining the hood helps to reduce the possibility of a hood fire occurring as well as ensuring the automatic fire suppression system functions as designed. The facility had a census of eighty nine residents on the day of survey. These deficiencies affected all residents, staff and visitors.</p> <p>Finding #1:</p> <p>During record review on September 11, 2013 at 10:30 AM, it was revealed that the last two kitchen hood inspection/cleaning reports were dated January 8, 2013 and July 30, 2013. The inspections/cleanings were conducted past the maximum time between inspections/cleanings of six months. When the Maintenance Supervisor was questioned about the overdue inspection/cleanings he stated that he was unsure why the inspections/cleanings exceeded the six month time frame.</p> <p>Finding #2:</p> <p>During record review on September 11, 2013 at 10:35 AM, it was revealed that the last two kitchen hood fire suppression system inspection reports were dated January 8, 2013 and July 30, 2013. The inspections were conducted past the maximum time between inspections of six months. When the Maintenance Supervisor was questioned about the overdue inspections he stated that he was unsure why the inspections</p>	K 069	<p><b>SPECIFIC RESIDENTS</b> No residents were directly affected by this practice.</p> <p><b>OTHER RESIDENTS</b> All residents are at risk from this deficient practice.</p> <p><b>SYSTEMATIC CHANGES</b> Maintenance has scheduled kitchen hood inspections to ensure that they are completed in accordance to NFPA requirements. administrator has met with advanced Fire Protection vendor to ensure service is provided in accordance to the schedule.</p>	10/10/13

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K 069	<p>Continued From page 3 exceeded the six month time frame.</p> <p>This is a repeat deficiency previously cited during the life safety code survey conducted on October 3, 2012.</p> <p>Actual NFPA Standard:</p> <p>Finding #1:</p> <p>NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations 2001 Edition 11.3 Inspection of Exhaust Systems. The entire exhaust system shall be inspected by a properly trained, qualified, and certified company or person(s) acceptable to the authority having jurisdiction in accordance with Table 11.3.</p> <p>Table 11.3 Exhaust System Inspection Schedule Systems serving moderate-volume cooking operations Semiannually</p> <p>11.4.1 Upon inspection, if found to be contaminated with deposits from grease-laden vapors, the entire exhaust system shall be cleaned by a properly trained, qualified, and certified company or person(s) acceptable to the authority having jurisdiction in accordance with Section 11.3.</p> <p>Finding #2:</p> <p>NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations 2001 Edition</p> <p>11.2 Inspection of Fire-Extinguishing Systems. 11.2.1* An inspection and servicing of the</p>	K 069	<p><b>MONITER</b></p> <p>Maintenance Director &amp; Executive Director will audit &amp; monitor suppression &amp; exhaust System monthly to ensure timely maintenance service has been scheduled for 01-09-14 &amp; 07-07-14. Next year service results will be reported to QA Committee on a monthly basis.</p> <p>Maintenance Director will bring kitchen hood inspection schedule monthly to PI to ensure timely service is completed.</p>	10/10/13

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

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K 069	Continued From page 4 fire-extinguishing system and listed exhaust hoods containing a constant or fire-actuated water system shall be made at least every 6 months by properly trained and qualified persons.	K 069		10/10/13	

Bureau of Facility Standards

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C 000	<p><b>16.03.02 INITIAL COMMENTS</b></p> <p>The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2.</p> <p>The facility is a 55,000 square foot single story type V(111) building constructed in 1997. It is fully sprinklered and has smoke detection throughout. Currently the facility is licensed for 121 SNF/NF beds.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on September 11, 2013. The facility was surveyed under IDAPA 16.03.02, Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities.</p> <p>The surveyor conducting the survey was:</p> <p>Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction</p>	C 000	<p style="text-align: center;"><b>RECEIVED</b></p> <p style="text-align: center;"><b>OCT - 1 2013</b></p> <p style="text-align: center;"><b>FACILITY STANDARDS</b></p>	10/10/13
C 226	<p><b>02.106 FIRE AND LIFE SAFETY</b></p> <p>106. FIRE AND LIFE SAFETY. Buildings on the premises used as facilities shall meet all the requirements of local, state and national codes concerning fire and life safety standards that are applicable to health care facilities.</p> <p>This Rule is not met as evidenced by: Refer to the following Federal "K" tags on the CMS - 2567:</p> <p>1. K046 Emergency lighting.</p>	C 226		<p>Please refer to Plan of Correction for K-069</p>

Idaho form  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
*Gregory A. Bolan*  
STATE FORM 021199

TITLE  
*Interim Executive Director*  
DM8V21

(X6) DATE  
*09-27-13*  
If continuation sheet 1 of 2

Bureau of Facility Standards

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C 226	Continued From Page 1  2. K069 Kitchen hood maintenance.	C 226		10/10/13