



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 Ecker Street  
P.O. Box 83720  
Boise, ID 83720-0009  
PHONE 208-334-6626  
FAX 208-364-1888

**CERTIFIED MAIL: 7012 3050 0001 2128 2590**

November 12, 2014

Irene Riggs, Administrator  
Life Care Center of Sandpoint  
1125 North Division Street  
Sandpoint, ID 83864-2148

Provider #: 135127

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

Dear Ms. Riggs:

On **November 4, 2014**, a Facility Fire Safety and Construction survey was conducted at **Life Care Center of Sandpoint** 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 one that comprises a pattern 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 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

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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 **November 25, 2014**. Failure to submit an acceptable PoC by **November 25, 2014**, may result in the imposition of civil monetary penalties by **December 15, 2014**.

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 and the state licensure survey report, State Form.

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 **December 9, 2014**, (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 **December 9, 2014**. A change in the seriousness of the deficiencies on **December 9, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **December 9, 2014**, includes the following:

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Denial of payment for new admissions effective **February 4, 2015**.  
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 **May 4, 2015**, 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 **November 4, 2014**, 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>

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Go to the middle of the page to Information Letters section and click on State and select the following:

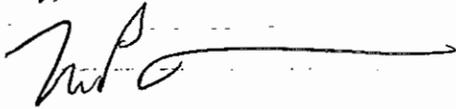
BFS Letters (06/30/11)

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

This request must be received by **November 25, 2014**. If your request for informal dispute resolution is received after **November 25, 2014**, 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 'MPG', followed by a long horizontal line 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: 11/12/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  11/04/2014
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NAME OF PROVIDER OR SUPPLIER <b>LIFE CARE CENTER OF SANDPOINT</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1125 NORTH DIVISION STREET SANDPOINT, ID 83864</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
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K 000	<p><b>INITIAL COMMENTS</b></p> <p>The facility is a single story, 55,000 square foot structure of Type V (111) construction that was completed in October of 1997. The building is protected throughout by an automatic fire extinguishing system and a fire alarm system with smoke detection. Currently the facility is licensed for 124 SNF/NF beds.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on November 4, 2014. 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>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	K 000	<p>This plan of correction is submitted as required by Federal and State statues applicable to long term 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 this plan does not constitute agreement by the facility that the surveyors' 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> <p style="text-align: center;">RECEIVED NOV 23 2014 FACILITY STANDARDS</p>	
K 012 SS=D	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that smoke barriers would resist the passage of smoke. Failure to maintain smoke barrier continuity could allow smoke and dangerous gases to pass freely and slowing smoke detection and suppression response, potentially allowing fires to grow beyond incipient stages. This deficient practice affected 18 residents, staff and visitors in 3 of 8 smoke</p>	K 012	<p>1) The ceiling tile in Central Supply was off due to work being performed on the zone valves. The Director of Maintenance communicated this to the surveyor at the time of the survey. The ceiling tile was placed back into the grid during survey.</p>	11-21-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Deane Riggs Executive Director TITLE: Executive Director (X6) DATE: 11/17/14

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 012	<p>Continued From page 1</p> <p>compartments on the date of the survey The facility is currently licensed for 124 SNF/NF beds and had a census of 74 on the day of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour conducted on November 4, 2014 from 10:00 AM to 1:30 PM, observation of the suspended ceiling area of the Central Supply found a ceiling tile missing from the grid ceiling. Interview of the Director of Maintenance found he was not aware of this ceiling tile being gone.</p> <p>2) During the facility tour conducted on November 4, 2014 from 10:00 AM to 1:30 PM, observation of the suspended ceiling area of the Kitchen janitor and dry storage found a total of 4 ceiling tiles out of place exposing gaps to the area above varying from 1 to 2 feet long by 2 to 3 inches wide.</p> <p>3) During the facility tour conducted on November 4, 2014 from 10:00 AM to 1:30 PM, observation of the suspended ceiling area of the 200 wing above the nurses station found two tiles with 3/4 inch by 3/4 inch chips in the corners, exposing the area above the ceiling. Interview of the Director of Maintenance found he was not aware these ceiling tiles were broken.</p> <p>Actual NFPA standard:</p> <p>19.1.6.2 Health care occupancies shall be limited to the types of building construction shown in Table 19.1.6.2. (See 8.2.1.) Exception*: Any building of Type I(443), Type I(332), Type II(222), or Type II(111) construction shall be permitted to include roofing systems</p>	K 012	<p>2) The four ceiling tiles in the kitchen area had shifted in the grids, most likely got hit by the broom or mop.</p> <p>The tiles have now been properly placed with no gaps present.</p> <p>3) The ceiling tile in the 200 wing by the nurse's station and therapy entrance had a small broken corner out of it.</p> <p>The ceiling tile has been replaced.</p> <p>The resident's had the potential to be affected by not ensuring the ceiling tile smoke barriers were intact and placed properly.</p> <p>Ceiling tiles will be inspected weekly to ensure proper placement and no gaps can be seen. Housekeeping and kitchen associates educated on ensuring broom and mop handles do not touch the ceiling tiles and if they do to report to maintenance for inspection of proper placement.</p>	

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K 012	<p>Continued From page 2</p> <p>involving combustible supports, decking, or roofing, provided that the following criteria are met:</p> <p>(a) The roof covering meets Class C requirements in accordance with NFPA 256, Standard Methods of Fire Tests of Roof Coverings.</p> <p>(b) The roof is separated from all occupied portions of the building by a noncombustible floor assembly that includes not less than 2 1/2 in. (6.4 cm) of concrete or gypsum fill.</p> <p>(c) The attic or other space is either unoccupied or protected throughout by an approved automatic sprinkler system.</p> <p>8.2.1* Construction. Buildings or structures occupied or used in accordance with the individual occupancy chapters (Chapters 12 through 42) shall meet the minimum construction requirements of those chapters. NFPA 220, Standard on Types of Building Construction, shall be used to determine the requirements for the construction classification. Where the building or facility includes additions or connected structures of different construction types, the rating and classification of the structure shall be based on either of the following:</p> <p>(1) Separate buildings if a 2-hour or greater vertically-aligned fire barrier wall in accordance with NFPA 221, Standard for Fire Walls and Fire Barrier Walls, exists between the portions of the building Exception: The requirement of 8.2.1(1) shall not apply to previously approved separations between buildings.</p> <p>(2) The least fire-resistive type of construction of the connected portions, if no such separation is provided</p>	K 012	<p>The weekly ceiling tile inspections will be added to our TELS program. This program will show the inspections are due weekly and maintenance has to go in and document once they are done the findings.</p> <p>The TELS program will be audited by the Executive Director (E.D.) to ensure compliance on a weekly basis for six weeks then monthly for three months.</p>	
K 052	NFPA 101 LIFE SAFETY CODE STANDARD	K 052		

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K 052 SS=F	<p>Continued From page 3</p> <p>A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure smoke detection systems were consistently maintained. Failure to maintain smoke detection would prevent the ability for the system to properly function during a fire event. This deficient practice affected residents, staff and visitors on the date of the survey. The facility is currently licensed for 124 SNF/NF beds and had a census of 74 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on November 4, 2014 from 10:00 AM to 1:30 PM, observation of the smoke/heat detector in the area behind the dryers of the laundry room found the detector was hanging haphazardly away from the electrical conduit and the detection relay outside of the 4 inch square mounting receptacle. When asked, the Director of Maintenance stated he was not aware of this condition prior to the survey date.</p> <p>Actual NFPA standard:</p>	K 052	<p>K052</p> <p>The heat detector in the laundry room behind the dryers was re-wired and put back into the mounting receptacle and hung back on the ceiling.</p> <p>Our yearly fire alarm/smoke detector inspection company has been contacted about this issue. They are going to speak to their Tech about being more thorough as he was just here to inspect all smoke/heat detectors in September 2014.</p> <p>The maintenance department will inspect all smoke/heat detectors weekly for four weeks, then monthly for three months, then quarterly to ensure working and properly installed.</p> <p>The TELS program will be used to ensure these inspections happen and are documented on a quarterly basis. The Executive Director will audit TELS for compliance.</p>	11-21-14

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K 052	Continued From page 4  9.6.1.4 A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm Code, unless an existing installation, which shall be permitted to be continued in use, subject to the approval of the authority having jurisdiction.	K 052		

Bureau of Facility Standards

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C 000	16.03.02 INITIAL COMMENTS  The facility is a single story, 55,000 square foot structure of Type V (111) construction that was completed in October of 1997. The building is protected throughout by an automatic fire extinguishing system and a fire alarm system with smoke detection. Currently the facility is licensed for 124 SNF/NF beds.  The following deficiencies were cited during the annual fire/life safety survey conducted on November 4, 2014. The facility was surveyed under the LIFE SAFETY CODE, 2000 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.  The Survey was conducted by:  Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	C 000		
C 226	02.106 FIRE AND LIFE SAFETY  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.  This Rule is not met as evidenced by: Please refer to "K" tags on CMS 2567  K 012 Smoke barrier continuity	C 226	See Plan of Correction for K 012	

RECEIVED  
NOV 25 2014  
FACILITY STANDARDS

Idaho form  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
*Alene Riggs*  
TITLE  
Executive Director  
(X6) DATE  
11/17/14  
STATE FORM 021199 MJ1G21 If continuation sheet 1 of 2

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED  11/04/2014
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C 226	Continued From Page 1  K 052 Fire alarm system maintenance	C 226	See Plan of Correction for K 052	