



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

December 17, 2014

Mark High, Administrator  
Life Care Center of Idaho Falls  
2725 East 17th Street  
Idaho Falls, ID 83406-6601

Provider #: 135091

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

Dear Mr. High:

On **December 10, 2014**, a Facility Fire Safety and Construction survey was conducted at **Life Care Center Of Idaho Falls** 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

Mark High, Administrator  
December 17, 2014  
Page 2 of 4

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 **December 30, 2014**. Failure to submit an acceptable PoC by **December 30, 2014**, may result in the imposition of civil monetary penalties by **January 19, 2015**.

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 **January 14, 2015**, (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 **January 14, 2015**. A change in the seriousness of the deficiencies on **January 14, 2015**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **January 14, 2015**, includes the following:

Mark High, Administrator  
December 17, 2014  
Page 3 of 4

Denial of payment for new admissions effective **March 10, 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 **June 10, 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 **December 10, 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>

Mark High, Administrator  
December 17, 2014  
Page 4 of 4

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 **December 30, 2014**. If your request for informal dispute resolution is received after **December 30, 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 'Mark P. Grimes', 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: 12/17/2014  
FORM APPROVED  
OMB NO. 0938-0391

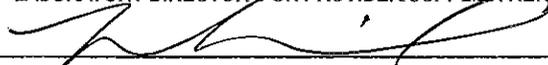
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135091</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02 - ENTIRE BUILDING</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/10/2014</b>
NAME OF PROVIDER OR SUPPLIER <b>LIFE CARE CENTER OF IDAHO FALLS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2725 EAST 17TH STREET IDAHO FALLS, ID 83406</b>		
(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	INITIAL COMMENTS  The facility is a single story Type V (III) building with partial basement housing hot water heaters. The fully sprinklered structure was built in 1978. A new smoke detection system was installed in 2011. A major renovation was completed in 1998. Currently it is licensed for 109 NF beds.  The following deficiency was cited at the above facility during the Fire/Life Safety survey conducted on December 10, 2014. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy and 42 CFR 483.70.  The surveyor conducting the survey was:  Nathan Elkins Health Facility Surveyor	K 000		
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1  This Standard is not met as evidenced by: Based on observation, operational testing and interview, it was determined that the facility did not ensure that hazardous area rooms were	K 029	A self-closing/automatic door closure apparatus has been installed on the storage room door #58.  All other doors within the facility that are marked storage or have combustibles located within the enclosure have also had self-closing/automatic door closures installed as per suggestion from state life safety surveyor.  Routine monitoring of the self-closing doors will be conducted through the maintenance TELS service.	1/5/2015

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

TITLE

(X6) DATE



Executive Director

12/29/14

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 029	<p>Continued From page 1</p> <p>constructed with self-closing doors. Hazardous area doors that do not self-close can allow smoke and fire gasses to enter the corridor in the event of a fire. The deficient practice affected one of six smoke compartments, 15 residents and staff. The facility has the capacity for 109 beds with a census of 75 residents on the day of survey.</p> <p>Findings include:</p> <p>During the tour of the facility on December 10, 2014, at approximately 11:00 AM, observation of the storage room door #58 was not on a self closure. The room was in excess of 50 square feet and was being used for storage of combustible materials on open shelving. Interview with the Maintenance Supervisor revealed that the facility was not aware the door did not self close.</p> <p>Actual NFPA Standard:</p> <p>19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:</p> <ol style="list-style-type: none"> <li>(1) Boiler and fuel-fired heater rooms</li> <li>(2) Central/bulk laundries larger than 100 ft<sup>2</sup> (9.3 m<sup>2</sup>)</li> <li>(3) Paint shops</li> <li>(4) Repair shops</li> </ol>	K 029	<p>A QA audit will be initiated and performed by the maintenance director or his designee. This will begin 12/29/2014 weekly X4 weeks, then monthly X3 then quarterly to assure proper functioning of all self-closing, automatic door closures. These audits will be reviewed and monitored in the PI minutes during monthly QI meeting.</p>	

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K 029	Continued From page 2 (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft <sup>2</sup> (4.6 m <sup>2</sup> ), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029			
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1  This Standard is not met as evidenced by: Based on observation, operational testing, and interview, it was determined that the facility had not ensured exit doors are arranged to be opened readily from the egress side. Failure to provide accessible exits can slow or prevent egress of 12 residents, staff members, and visitors to a public way on the day of survey. The facility had a census of 75 residents on the day of the survey.  Finding Include:  During the tour of the facility on December 10, 2014 at 11:00 AM, observation and operational testing of the delayed egress exit door from the	K 038	The delayed egress exit door in the main entry has been readjusted per manufactures criteria and are now functioning appropriately as per a service call from Stanley Access Technologies on 12/11/2014.  All other delayed egress doors and the courtyard gates have been inspected and tested to assure that they are accessible and are working properly.  Quarterly preventative maintenance schedule has been established with Stanley Access Technologies and routine monitoring of the delayed egress doors and all courtyard entry/exit gates, performed weekly via the TELS system, to assure proper functioning will be ongoing.	1/5/2015	

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K 038	<p>Continued From page 3</p> <p>main entry revealed that the lock would not begin an irreversible process to release within 15 seconds upon application of a force to the release device. When this deficiency was discussed with the Maintenance Supervisor he stated that the facility was unaware that the delayed egress releasing system was not functioning properly.</p> <p>Actual NFPA Standard: NFPA 101® Life Safety Code ® 2000 Edition</p> <p>19.2 MEANS OF EGRESS REQUIREMENTS 19.2.1 General. Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7.</p> <p>7.2 MEANS OF EGRESS COMPONENTS 7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed-egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met.</p> <p>(a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6.</p> <p>(b) The doors shall unlock upon loss of power controlling the lock or locking mechanism.</p> <p>(c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be</p>	K 038	<p>A QA audit will be initiated and performed by the maintenance director or his designee. This will begin 12/29/2014 weekly X4 weeks, then monthly X3 to assure proper functioning of all delayed egress exit. These audits will be reviewed and monitored in the PI minutes during monthly QI meeting.</p>	

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

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135091</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02 - ENTIRE BUILDING</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>12/10/2014</b>
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K 038	Continued From page 4 required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) * On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: <b>PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS</b>	K 038			

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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 single story Type V (III) building with partial basement housing hot water heaters. The fully sprinklered structure was built in 1978. A new smoke detection system was installed in 2011. A major renovation was completed in 1998. Currently it is licensed for 109 NF beds.</p> <p>The following deficiency was cited at the above facility during the Fire/Life Safety survey conducted on December 10, 2014. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy and 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>Nathan Elkins Health Facility Surveyor</p>	C 000		
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. This RULE: is not met as evidenced by: Refer to the following Federal "K" tag on the CMS - 2567:</p> <p>K029 - Hazardous Areas</p>	C 226	<p>Refer to K029</p>	<p>1/5/2015</p>

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FACILITY STANDARDS

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

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Executive Director

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C 226	Continued From Page 1  K038 - Exits and Egress	C 226	Refer to K038	1/5/2015

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