



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 18, 2014

Josiah Dahlstrom, Administrator  
Idaho State Veterans Home-- Pocatello  
1957 Alvin Ricken Drive  
Pocatello, ID 83201-2727

Provider #: 135132

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

Dear Mr. Dahlstrom:

On **December 11, 2014**, a Facility Fire Safety and Construction survey was conducted at **Idaho State Veterans Home - Pocatello** 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 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

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provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **December 31, 2014**. Failure to submit an acceptable PoC by **December 31, 2014**, may result in the imposition of civil monetary penalties by **January 20, 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 15, 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 15, 2015**. A change in the seriousness of the deficiencies on **January 15, 2015**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **January 15, 2015**, includes the following:

Denial of payment for new admissions effective **March 11, 2015**.  
42 CFR §488.417(a)

Josiah Dahlstrom, Administrator  
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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 11, 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 11, 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>

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

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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 31, 2014**. If your request for informal dispute resolution is received after **December 31, 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', 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: 12/17/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135132</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - ENTIRE BUILDING</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/11/2014</b>
NAME OF PROVIDER OR SUPPLIER <b>IDAHO STATE VETERANS HOME - POCATELL</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1957 ALVIN RICKEN DRIVE POCATELLO, ID 83201</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 II(111) fire resistive fully sprinklered building built in 1992-93. Smoke detection coverage is provided throughout the facility including sleeping rooms. There is a lower level mechanical room with only exterior access. Currently the facility is licensed for 66 beds.  The following deficiencies were cited during the annual fire/life safety survey conducted on December 11, 2014. The facility was surveyed under the LIFE SAFETY CODE 2000 Edition, Existing Health Care Occupancy and 42 CFR 483.70.  The survey was conducted by:  Nathan Elkins Health Facility Surveyor	K 000		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3  Roller latches are prohibited by CMS regulations in all health care facilities.	K 018		

*Received 12/22/14 go*

RECEIVED  
JAN - 2 2015

FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE  
*Special Dahlstrom* Administrator 12/30/14

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 018	Continued From page 1  This Standard is not met as evidenced by: Based on observation and operational testing, the facility failed to protect corridor openings with doors capable of resisting the passage of smoke. The deficient practice affected one of four smoke compartments, approximately 11 residents, and staff members. The facility is licensed for 66 SNF/NF beds with a census of 47 on the day of survey.  Findings include:  During the tour of the facility on December 11, 2014, at approximately 2:00 PM, observation and operational testing revealed that the Library door in the East Wing corridor did not close and latch properly. Discussion with the Maintenance Supervisor revealed the facility was unaware the door did not close and latch properly.  Actual NFPA Standard: 19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1 3/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception No. 1: Doors to toilet rooms,	K 018	K 018 <ul style="list-style-type: none"><li>The Library door was fixed 12/12/14. The molding that was installed around the door frame was adjusted to ensure a proper closure and latching and a picture of the remedy was emailed to the Bureau of Facility Standards on 12/12/14.</li><li>The building was inspected on 12/11/14 with the Health Facility Surveyor and our facility Foreman and no other resident areas were identified as a similar risk.</li><li>Staff are aware of this standard and will inform the maintenance team of any doors that do not close/latch completely. This corrective action will be monitored as staff are in and out of most doors in the facility on a daily basis and noted concerns will be taken to the maintenance team.</li></ul> <u>Corrective action completion date:</u>	12/12/14

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K 018	Continued From page 2 bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke	K 018		
K 029 SS=D	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 and operational testing, it was determined that the facility did not ensure that hazardous area rooms were constructed with self closing doors. Hazardous area doors that do not self close can allow smoke and fire gasses to move rapidly in the event of a fire. This deficient practice affected residents, staff and visitors utilizing the main dining room on the date of the survey. The facility is licensed for 66 SNF/NF beds and had a census of 47 on the day of the survey.	K 029		

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K 029	<p>Continued From page 3 Findings Include</p> <p>During the facility tour conducted on December 11, 2014 at approximately 2:45 PM, observation of the Eastside door leading from dining room to the kitchen had a kick-down style door stop installed, impeding closure of the doors. Operational testing revealed both the Eastside and Westside doors leading to and from the kitchen area were not self closing. Discussion with the Maintenance Supervisor revealed the facility was aware of the impediments on the Eastside door but was unaware the doors needed to be self closing.</p> <p>Actual NFPA standard:</p> <p><b>3.3.13.2 Area, Hazardous.</b> An area of a structure or building that poses a degree of hazard greater than that normal to the general occupancy of the building or structure, such as areas used for the storage or use of combustibles or flammables; toxic, noxious, or corrosive materials; or heat-producing appliances.</p> <p><b>19.3.2.1 Hazardous Areas.</b> 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: (1) Boiler and fuel-fired heater rooms</p>	K 029	<p>K 029</p> <ul style="list-style-type: none"> <li>Mag locks will be placed on both the east side and west side doors between the dining room and the kitchen. The local contracted vendor for this home has been contacted and will visit the facility the week of 1/5/14 to submit a proposal. Depending on the expense, the project may need separate bid, at which point in time the Bureau of Facility Standards will be informed of the anticipated time frame.</li> <li>The building was inspected on 12/11/14 with the Health Facility Surveyor and our facility Foreman and no other resident areas were identified as a similar risk.</li> <li>This remedy is a permanent change that will not require further monitoring as human error is removed from the equation.</li> </ul> <p><u>Corrective action completion date:</u></p>	1/31/15

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K 029	Continued From page 4 (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), 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		

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NAME OF PROVIDER OR SUPPLIER IDAHO STATE VETERANS HOME - POCATELLO		STREET ADDRESS, CITY, STATE, ZIP CODE 1957 ALVIN RICKEN DRIVE POCATELLO, ID 83201		
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C 000	<p>16.03.02 INITIAL COMMENTS</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 II(111) fire resistive fully sprinklered building completed in 1993. Smoke detection coverage is provided throughout the facility including sleeping rooms. The structure has a lower level mechanical room with exterior access only. Currently the facility is licensed for 66 beds.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on December 11, 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 survey was conducted by:</p> <p>Nathan Elkins Health Facility Surveyor</p>	C 000	<p>Received 12/22/14 GD</p> <p>RECEIVED JAN - 2 2015 FACILITY STANDARDS</p>	
C 226	<p>02.106 FIRE AND LIFE SAFETY</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: Please refer to "K" tag on CMS 2567:</p> <p>K 018 Corridor Walls and Doors</p>	C 226	<p>See K 018</p> <p>Corrective action completion date: 12/12/14</p>	

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

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

*Josiah Dahlstrom*

TITLE

*Adrian Shator*

(X6) DATE

12/30/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135132</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - ENTIRE BUILDING</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/11/2014</b>
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C 226	Continued From Page 1  K 029 Hazardous Area Doors	C 226	See K 029  <u>Corrective action completion date:</u>	1/31/15

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