



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR  
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BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P. O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: (208) 334-6626  
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February 18, 2017

Richard Ord, Administrator  
Bennett Hills Center  
1220 Montana Street  
Gooding, ID 83330-1856

Provider #: 135134

Dear Mr. Ord:

On **February 9, 2017**, a survey was conducted at Bennett Hills Center by the Idaho Department of Health and Welfare, Division of Licensing and Certification, 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/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated 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. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct." **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

Richard Ord, Administrator  
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After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **February 28, 2017**. Failure to submit an acceptable PoC by **February 28, 2017**, may result in the imposition of penalties by **March 9, 2017**.

The components of a Plan of Correction as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained; and
- Include dates when corrective action will be completed in column (X5).

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

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 **March 16, 2017 (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 **May 10, 2017**. A change in the seriousness of the deficiencies on **March 26, 2017**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **May 10, 2017** includes the following:

Denial of payment for new admissions effective **May 10, 2017**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying non-compliance, 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 **August 8, 2017**, 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, CMS will provide you with a separate formal notification of that determination.**

If you believe these deficiencies have been corrected, you may contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; fax number: (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 **May 10, 2017** 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/NursingFa>

Richard Ord, Administrator  
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[ilities/tabid/434/Default.aspx](#)

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 **February 28, 2017**. If your request for informal dispute resolution is received after **February 28, 2017**, 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, comments or concerns, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2.

Sincerely,

A handwritten signature in cursive script, appearing to read "David Scott for".

David Scott, RN, Supervisor  
Long Term Care

ds/dr  
Enclosures

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

PRINTED: 03/03/2017  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135134</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/09/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>BENNETT HILLS CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1220 MONTANA STREET GOODING, ID 83330</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	
F 000	INITIAL COMMENTS  The following deficiencies were cited during the federal recertification and complaint investigation surveys conducted at the facility from Febraury 6, 2017 to Febraury 9, 2017.  The surveyors conducting the survey were:  Presie C. Billington, RN, Team Coordinator Debra Parker, RN  Survey Abbreviation: DON - Director of Nursing ER - Extended Release LN - License Nurse MAR - Medication Administration Record mg - milligram mmHg - Millimeters of Mercury	F 000			
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  (b)(3) Comprehensive Care Plans  The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-  (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to assess residents' blood pressure and/or heart rate prior to the administration of anti-hypertensive medication in accordance with professional standards of practice. This was true for 2 of 10 residents (#4 and #9) who received Metropolol. This deficient practice placed residents at risk of harm due to	F 281	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Bennett Hills Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The	3/10/17	

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

TITLE

(X6) DATE

Electronically Signed

02/27/2017

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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F 281	<p>Continued From page 1</p> <p>hypotension and decreased heart rate. Findings include:</p> <p>1. Resident #4 was admitted to the facility on 8/28/15, with diagnoses that included tachycardia.</p> <p>Physician Orders, dated 2/1/17, documented Resident #4 was to receive Metoprolol 50 mg twice daily for tachycardia.</p> <p>Medication Administration Records (MARs) for November 2016 through 2/8/17 documented Resident #4 received the medication as ordered.</p> <p>The clinical record documented Resident #4's heart rate was assessed five times in November 2016, twice in December 2016, and twice in January 2017.</p> <p>The Nursing 2016 Drug Handbook by Wolters Kluwer documented Metoprolol was contraindicated for residents whose heart rate is less than 45 beats-per-minute (bpm) or for residents with a systolic blood pressure of less than 100 mm Hg.</p> <p>2. Resident #9 was admitted to the facility on 11/7/16, and readmitted 1/30/17, with diagnoses that included hypertension.</p> <p>Physician Orders documented Resident #9 was to receive Metoprolol succinate ER 25 mg daily for hypertension, but that the medication was to be held if the resident's heart rate was less than 60 bpm.</p> <p>MARs for November 2016 through 2/8/17</p>	F 281	<p>Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.</p> <p>F 281</p> <p><b>Affected Residents</b></p> <p>On 2/21/17 residents # 4 was assessed by the Assistant Director of Nursing for symptoms of Hypotension and decreased heart rate, no associated symptoms identified. On or before 2/24/16 the Assistant Director of Nursing reviewed resident # 4's orders for Metoprolol and updated B/P and/or pulse parameters for metoprolol administration as indicated. MD and responsible party notified &amp; care plan updated as indicated.</p> <p>On 2/21/17 residents # 9 was assessed by the Assistant Director of Nursing for symptoms of Hypotension and decreased heart rate, no associated symptoms identified. On or before 2/24/16 the Assistant Director of Nursing reviewed resident # 4's orders for Metoprolol and updated B/P and/or pulse parameters for metoprolol administration as indicated.</p> <p>MD and responsible party notified &amp; care plan updated as indicated.</p> <p><b>Potential Residents</b></p> <p>On or before 3/10/17 a review of residents currently receiving antihypertensive medications will be</p>		

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F 281	<p>Continued From page 2</p> <p>documented Resident #9 received the Metoprolol as ordered, including 1/31/17 when the resident's heart rate was 54 bpm. Resident #9's clinical record did not include documentation that the physician was notified of the low heart rate prior to the Metoprolol administration.</p> <p>On 2/9/17 at 8:40 am, LN #1 stated blood pressure and heart rate should be assessed prior to the administration of Metoprolol and that the medication should be held when a resident's systolic blood pressure was less than 100 mm Hg or when the resident's pulse was less than 60.</p> <p>On 2/9/17 at 8:45 am, LN #2, stated blood pressure should be assessed prior to the administration of Metoprolol only if so ordered by a physician.</p> <p>On 2/9/17 at 9:37 am, LN #3 stated blood pressure should "definitely" be assessed and a pulse "probably" assessed prior to the administration of Metoprolol.</p> <p>On 2/9/17 at 10:05 am, the DON stated nurses assessed vitals prior to the administration of Metoprolol only if so ordered by a resident's physician, as some physicians did not want vital signs taken daily. She said the facility did not have a policy related to the assessment of vital signs prior to the administration of some medications.</p> <p>The 2017 Nursing Drug Handbook documents, "Always check patient's apical pulse rate before giving the drug [Metoprolol]. If [heart rate is] slower than 60 beats/minute, withhold drug and</p>	F 281	<p>completed by the Director of Nursing or designee, to identify residents that require monitoring &amp; of blood pressure and/or pulse prior to antihypertensive medication administration. Parameters &amp; follow-up will be completed as indicated for identified residents and care plans will be updated for respective residents.</p> <p>Systemic On or before 3/10/17, Licensed Nurses will receive education by the Director of Nursing or designee, regarding guidelines for parameters and blood pressure and/or pulse monitoring for residents receiving antihypertensive medications. On or before 3/10/17, the Director of Nursing or designee will review new/changed antihypertensive medications orders in clinical meeting to ensure that blood pressure and/or pulse parameters are implemented as indicated per facility guidelines. Follow up will be completed as indicated.</p> <p>Monitoring - QA Audit Beginning week of 3/10/17 the Director of Nursing or designee will review 3 residents with antihypertensive medications to ensure that Blood Pressure and/or pulse parameters are in place per facility guidelines and monitoring &amp; follow up are completed as indicated. The Director of Nursing is responsible for monitoring and follow-up.</p> <p>Audits will be completed weekly X 4 then Monthly X 2. Results will be reviewed by</p>		

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F 281	Continued From page 3 call prescriber immediately."	F 281	IDT during the QAPI meeting monthly for 3 months or until substantial compliance is achieved. The Director of Nursing is responsible for monitoring and follow-up.		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001235</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/09/2017</b>
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C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The following deficiencies were cited during the State licensure survey and complaint investigation conducted at the facility from February 6 to Febraury 9, 2017.</p> <p>The surveyors conducting the survey were:</p> <p>Presie C. Billington, RN, Team Coordinator Debra Parker, RN</p> <p>Definitions include:</p> <p>CNA - Certified Nursing Assistant DON - Director of Nursing LN - License Nurse MD - Medical Director NPE - Nurse Practice Educator PR - Pulse Rate</p>	C 000		
C 664	<p>02.150,02,a Required Members of Committee</p> <p>a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative.</p> <p>This Rule is not met as evidenced by: Based on review of the Infection Control Meeting minutes and staff interview, it was determined the facility failed to ensure a representative from each department was present at quarterly Infection Control Meetings. This failure had the potential to adversely affect all residents, staff and visitors to the facility if infection control concerns and practices were not uniformly known and adhered to throughout the facility. Findings include:</p>	C 664	<p>C664 Required Members of the Committee</p> <p>On 2/21/17 An infection control meeting was held which included the Medical Director, Infection Control Coordinator, Director of Nursing, Administrator, and representatives from Housekeeping, Maintenance, Dietary, &amp; Pharmacy. The signature log was verified by the Administrator or designee to include</p>	3/10/17

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Electronically Signed	TITLE	(X6) DATE <b>02/27/17</b>
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C 664	<p>Continued From page 1</p> <p>On 2/8/17 at 9:20 am, the Nurse Practice Educator provided Monthly Infection Control Minutes and sign-in sheets for April 2016 through January 2017. The attendance records documented the following:</p> <ul style="list-style-type: none"> <li>*Dietary Department did not attend meetings from April 2016 to October 2016</li> <li>*Housekeeping/Laundry Department attended only the August and December 2016 meetings</li> <li>*Maintenance Department attended only the August 2016 meeting</li> <li>*Pharmacy Department attended only the November 2016 meeting</li> </ul>	C 664	<p>signatures from the above departments.</p> <p>Potential The minutes of the infection control meetings held for the last 90 days were reviewed with the centers Infection control committee by the Director of Nursing on 2/21/17. No further action is indicated.</p> <p>Systemic On or before 3/10/17 the Administrator or designee will provide an agenda of scheduled Infection Control Meetings to the Medical Director, Infection Control Coordinator, Director of Nursing, and Housekeeping, Maintenance, Dietary, &amp; Pharmacy departments.</p> <p>On 2/21/17 the Administrator or designee provided education to required Department attendees regarding Infection Control Meeting regulatory attendance requirements.</p> <p>Monitoring - QA Audit Beginning the week of 3/10/17 the Infection Control meeting signature logs will be reviewed by the Administrator monthly to ensure that a member from each department is present as per state regulatory requirements.</p> <p>From the results of these audits the Administrator will review for regulatory compliance of attendance in the Performance Improvement Committee meetings monthly. Attendance trends will be acted upon for 3 months to achieve compliance of attendance by the required</p>	

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C 664	Continued From page 2	C 664	attendees to the infection control meeting.	