



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSSELL S. BARRON – Director

TAMARA PRISOCK – ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
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

August 17, 2018

Emily Engberson, Administrator
Advanced Health Care of Coeur d'Alene
1578 W. Riverstone Drive
Coeur d'Alene, ID 83814

Provider #: 135142

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Ms. Engberson:

On **August 6, 2018**, a Facility Fire Safety and Construction survey was conducted at **Advanced Health Care of Coeur D'Alene** 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. 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. Please provide **ONLY ONE** completion date for each federal and state tag in column (X5) Completion Date to signify when

Emily Engberson, Administrator
August 17, 2018
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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 the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office. If a State Form with deficiencies was issued, it should be signed, dated and returned along with the CMS-2567 Form.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **August 30, 2018**. Failure to submit an acceptable PoC by **August 30, 2018**, may result in the imposition of civil monetary penalties by **September 21, 2018**.

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. If a State Form was issued as well, it should also be signed, dated and returned.

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

Remedies may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **September 10, 2018**, (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 **September 10, 2018**. A change in the seriousness of the deficiencies on **September 10, 2018**, may result in a change in the remedy.

Emily Engberson, Administrator
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The remedy, which will be recommended if substantial compliance has not been achieved by **September 10, 2018**, includes the following:

Denial of payment for new admissions effective **November 6, 2018**.
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 **February 6, 2019**, 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 Nate Elkins, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, option 3; 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 **August 6, 2018**, 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:

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<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:

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 **August 30, 2018**. If your request for informal dispute resolution is received after **August 30, 2018**, 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, option 3.

Sincerely,



Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosures

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

Printed: 08/15/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135142	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ADVANCED HEALTHCARE COEUR D ALENE B. WING _____	(X3) DATE SURVEY COMPLETED 08/06/2018
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NAME OF PROVIDER OR SUPPLIER ADVANCED HEALTH CARE OF COEUR D'ALENE	STREET ADDRESS, CITY, STATE, ZIP CODE 1578 W RIVERSTONE DRIVE COEUR D'ALENE, ID 83814
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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>INITIAL COMMENTS</p> <p>The facility consists of a single story, Type V (111) structure with hazardous area separations. The building is fully sprinklered and has a complete fire alarm/smoke detection system including open areas and using beam detection in the open clear-story hallways housing resident rooms. The facility is separated into three smoke compartments and is equipped with a Type 2 medical gas system and Type 1 EPSS (Emergency Power Supply System) diesel-fired generator. Currently the facility is licensed for 34 SNF/NF beds with a census of 34 on the date of the survey.</p> <p>The following deficiencies were cited during the annual Fire/Life Safety survey conducted on August 6, 2018. The facility was surveyed under the LIFE SAFETY CODE, 2012 edition, Existing Healthcare Occupancies, in accordance with 42 CFR 483.70.</p> <p>The survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction</p>	K 000	<p style="text-align: center;">AUG 28 2018</p> <p style="text-align: center;">FACILITY STANDARDS</p>	
K 291 SS=F	<p>Emergency Lighting CFR(s): NFPA 101</p> <p>Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9.18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure doors equipped with special locking arrangements, were provided with battery powered emergency lighting in accordance with</p>	K 291	<p>K291</p> <p>Systemic Changes:</p> <p>Battery backup lighting will be installed at exits that have a delayed egress.</p> <p>Surveillance:</p> <p>Administrator or her designee will ensure work is completed and report findings to the QA Committee.</p> <p>Date of Compliance: 9/10/18</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X8) DATE 8/28/18

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 291	<p>Continued From page 1</p> <p>NFPA 101. Failure to provide emergency lighting for doors equipped with delayed egress potentially hinders identification of exits utilized for resident egress during an emergency. This deficient practice affected 34 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 8/6/18 from approximately 10:00 - 11:30 AM, observation of the front entrance revealed this door was equipped with magnetic locking arrangements, which included a delayed egress component, however the door was not provided with battery powered emergency lighting.</p> <p>Asked about this arrangement, the Facility Manager stated that the facility primary exit doors had been modified from the original installation, to include a Wandergaurd/magnetic locking arrangement. He further verified the delayed egress component was included as part of that system and substantiated that battery backup emergency lighting had not been included as part of that installation.</p> <p>Actual NFPA standard:</p> <p>19.2.9 Emergency Lighting. 19.2.9.1 Emergency lighting shall be provided in accordance with Section 7.9.</p> <p>7.9 Emergency Lighting. 7.9.1 General. 7.9.1.1* Emergency lighting facilities for means of egress shall be provided in accordance with Section 7.9 for the following: (1) Buildings or structures where required in Chapters 11 through 43</p>	K 291		

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NAME OF PROVIDER OR SUPPLIER ADVANCED HEALTH CARE OF COEUR D'ALENE		STREET ADDRESS, CITY, STATE, ZIP CODE 1578 W RIVERSTONE DRIVE COEUR D'ALENE, ID 83814		
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K 291	Continued From page 2 (2) Underground and limited access structures as addressed in Section 11.7 (3) High-rise buildings as required by other sections of this Code (4) Doors equipped with delayed-egress locks (5) Stair shafts and vestibules of smokeproof enclosures, for which the following also apply: (a) The stair shaft and vestibule shall be permitted to include a standby generator that is installed for the smokeproof enclosure mechanical ventilation equipment. (b) The standby generator shall be permitted to be used for the stair shaft and vestibule emergency lighting power supply. (6) New access-controlled egress doors in accordance with 7.2.1.6.2.	K 291		
K 341 SS=F	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.6 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility	K 341	K 341 Systemic Changes: Fire pull station in the oxygen room will be moved to a height between 42"-48". Surveillance: Administrator or her designee will ensure work is completed and report findings to the QA Committee. Date of Compliance: 9/10/18	

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K 341	<p>Continued From page 3</p> <p>failed to ensure that manual pull stations were installed in accordance with NFPA 72. Failure to provide manual fire alarm boxes as prescribed under the standard, has the potential to hinder access and activation of the alarm box during a fire. This deficient practice affected 34 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 8/6/18 from 10:00 - 11:30 AM, observation of the manual fire alarm box mounted on the left side of the exit door in the oxygen supply/storage room, revealed the pull station had been relocated from the original installation height of approximately 42 - 48 inches and relocated to approximately 63 inches when measured from the floor.</p> <p>When asked about the change in the location of the pull station, the Facility Manager stated the box had been moved up to that height after installation of the piped medical gas cryogenic cylinders and based on the direction of the medical gas supplier.</p> <p>Actual NFPA standard:</p> <p>17.14.4 The operable part of each manual fire alarm box shall be not less than 42 in. (1.07 m) and not more than 48 in. (1.22 m) above floor level.</p> <p>17.14.5 Manual fire alarm boxes shall be installed so that they are conspicuous, unobstructed, and accessible.</p>	K 341		
K 353 SS=F	<p>Sprinkler System - Maintenance and Testing CFR(s): NFPA 101</p> <p>Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are</p>	K 353		

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K 353	<p>Continued From page 4</p> <p>inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to ensure that fire suppression systems were maintained in accordance with NFPA 25. Failure to maintain the fire suppression dry system has the potential to allow water to prematurely enter the system during freezing and/or hinder system performance during a fire event. This deficient practice effected 34 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During review of provided facility inspection and testing records conducted on 8/6/18 from 8:30 - 10:00 AM, no records were available for weekly inspection of the dry system gauges.</p> <p>Actual NFPA standard: NFPA 25</p>	K 353	<p>K353</p> <p>Systemic Changes:</p> <p>A form has been created to monitor the three pressure gauges on the dry system.</p> <p>Surveillance:</p> <p>Administrator of her designee will audit compliance weekly x 4 and monthly x 3. Findings will be reported to the QA Committee.</p> <p>Date of Compliance: 8/10/18</p>	

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K 353	Continued From page 5 5.2.4 Gauges. 5.2.4.2 Gauges on dry, preaction, and deluge systems shall be inspected weekly to ensure that normal air and water pressures are being maintained.	K 353		
K 923 SS=D	Gas Equipment - Cylinder and Container Storage CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure	K 923	K923 Systemic Changes: Empty oxygen cylinders have been removed from the facility. A sign to distinguish empty cylinders has been put on wall. Surveillance: Administrator or her designee will audit compliance weekly x 4 and monthly x 3. Findings will be reported to the QA Committee. Date of Compliance: 8/10/18	

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K 923	<p>Continued From page 6</p> <p>considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure medical gases were stored in accordance with NFPA 99. Failure to segregate and identify compressed medical gas cylinders as full or empty, has the potential to inadvertently use the incorrect cylinder during an emergency requiring supplemental oxygen. This deficient practice affected those residents requiring supplemental oxygen treatment, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 8/6/18 from 10:00 - 11:30 AM, observation of the oxygen storage room revealed six (6) "E" cylinders stored in addition to the piped oxygen supply. Further observation failed to demonstrate a method to identify which cylinders were empty and which were full. When asked, the Administrator stated the facility did not use these types of cylinders regularly, but was aware that segregation was required.</p> <p>Actual NFPA standard:</p> <p>NFPA 99</p> <p>11.6.5 Special Precautions - Storage of Cylinders and Containers. 11.6.5.1 Storage shall be planned so that cylinders can be used in the order in which they are received from the supplier. 11.6.5.2 If empty and full cylinders are stored</p>	K 923		
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K 923	Continued From page 7 within the same enclosure, empty cylinders shall be segregated from full cylinders. 11.6.5.3 Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed in a rapid manner.	K 923		



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FAX 208-364-1888

August 17, 2018

Emily Engberson, Administrator
Advanced Health Care of Coeur d'Alene
1578 W. Riverstone Drive
Coeur d'Alene, ID 83814

Provider #: 135142

RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER

Dear Ms. Engberson:

On **August 6, 2018**, an Emergency Preparedness survey was conducted at Advanced Health Care of Coeur d'Alene by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. Your facility was found to be in substantial compliance with Federal regulations during this survey.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, which states that the facility complies with the requirements of CFR 42, 483.70(a) of the federal requirements. This form is for your records only and does not need to be returned.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact this office at (208) 334-6626, option 3.

Sincerely,

Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj

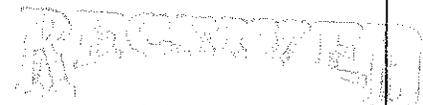
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135142	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/06/2018
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NAME OF PROVIDER OR SUPPLIER ADVANCED HEALTH CARE OF COEUR D'ALENE	STREET ADDRESS, CITY, STATE, ZIP CODE 1578 W RIVERSTONE DRIVE COEUR D'ALENE, ID 83814
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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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E 000	<p>Initial Comments</p> <p>The facility consists of a single story, Type V (111) structure with hazardous area separations. The building is located in a municipal fire district with full support of both state and county EMS services. It is fully sprinklered and has a complete fire alarm/smoke detection system including open areas and using beam detection in the open clear-story hallways housing resident rooms. The facility is separated into three smoke compartments and is equipped with a Type 2 medical gas system and Type 1 EPSS (Emergency Power Supply System), diesel-fired generator. Currently the facility is licensed for 34 SNF/NF beds with a census of 34 on the date of the survey.</p> <p>The facility was found to be in substantial compliance during the Emergency Preparedness survey conducted on August 6, 2018. The facility was surveyed under Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73.</p> <p>The survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction</p>	E 000	<p style="text-align: center;">  AUG 28 2018 FACILITY COMPLIANCE </p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator 8/21/18	(X8) DATE
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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.