



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

.BRAD LITTLE – Governor  
DAVE JEPPESEN – 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

January 9, 2020

Jordan Thompson, Administrator  
Valley View Nursing & Rehabilitation  
1140 North Allumbaugh Street  
Boise, ID 83704-8700

Provider #: 135098

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

Dear Mr. Thompson:

On **January 7, 2020**, a Facility Fire Safety and Construction survey was conducted at **Valley View Nursing & Rehabilitation** 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. 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)

Jordan Thompson, Administrator  
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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 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 **January 22, 2020**. Failure to submit an acceptable PoC by **January 22, 2020**, may result in the imposition of civil monetary penalties by **February 13, 2020**.

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 **February 11, 2020**, (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 **April 6, 2020**. A change in the seriousness of the deficiencies on **February 21, 2020**, 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 **February 11, 2020**, includes the following:

Denial of payment for new admissions effective **April 7, 2020**.  
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 **July 7, 2020**, 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 **January 7, 2020**, 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:

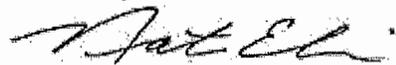
BFS Letters (06/30/11)

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

This request must be received by **January 22, 2020**. If your request for informal dispute resolution is received after **January 22, 2020**, 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

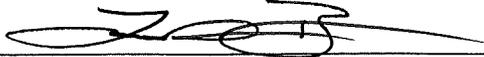
NE/lj  
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135098	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  01/07/2020
NAME OF PROVIDER OR SUPPLIER  VALLEY VIEW NURSING & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1140 NORTH ALLUMBAUGH STREET BOISE, ID 83704	
(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 two-story Type II (111) construction completed in 1985, with a complete renovation in 2009. There is a two-hour fire separation between the skilled nursing facility and the attached retirement center apartments. The fire alarm system was upgraded in 2009 with addressable smoke detection throughout the building. The fire sprinkler system was also upgraded in 2009 with quick response heads throughout. The facility is currently licensed for 120 SNF/NF beds and had a census of 78 on the dates of the survey.  The following deficiencies were cited during the annual fire/life safety survey conducted on January 6 - 7, 2020. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.  The Survey was conducted by:  Linda Chaney Health Facility Surveyor Facility Fire Safety & Construction	K 000	This plan of Correction is submitted as required under State and Federal regulations and statues applicable to long-term providers. The plan of correction does not constitute an admission of liability on the part of the facility, and such liability is specifically denied. The submission of this plan of Correction does not constitute an agreement by the facility that the surveyors findings and/or conclusions constitute a deficiency, or that the scope and severity of the deficiencies cited are correctly applied.	
K 923 SS=E	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	K 923	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;  Valley View Nursing and Rehabilitation purchased full and empty tags to define if each individual cylinder is full, empty, or in use. The full and empty cylinders are also segregated by full and empty with a label on the wall to eliminate confusion.	

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

TITLE

(X6) DATE



ADMINISTRATOR

1/17/2020

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135098	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE BUILDING  B. WING _____		(X3) DATE SURVEY COMPLETED  01/07/2020
NAME OF PROVIDER OR SUPPLIER  VALLEY VIEW NURSING & REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1140 NORTH ALLUMBAUGH STREET BOISE, ID 83704		
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K 923	<p>Continued From page 1</p> <p>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.</p> <p>Less than or equal to 300 cubic feet</p> <p>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."</p> <p>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 considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather.</p> <p>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:</p> <p>Based on observation and interview, the facility failed to ensure medical gases were stored in accordance with NFPA 99. Failure to label empty cylinders and segregate full and empty cylinders, has the potential to confuse and delay the selection of a full cylinder when needed in a rapid manner. This deficient practice had the potential to affect 18 oxygen dependent residents on the dates of the survey.</p>	K 923	<p>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;</p> <p>Residents residing in the facility who are oxygen dependent (18 residents) also had the potential to be affected by the deficient practice. Valley View implemented our tagging program which eliminates the confusion and delay time of whether each individual cylinder is full, empty or in-use.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;</p> <p>Valley View Nursing and Rehabilitation purchased full, empty and in-use labels and tagged all cylinders. Maintenance Director also created a tagging program on 1/28/2020 related to proper tagging of oxygen cylinders.</p>	2/1/2020

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K 923	Continued From page 2 Findings include:  During the facility tour conducted on January 7, 2020, from approximately 10:00 AM - 2:00 PM, observation of the oxygen storage room revealed two storage racks for oxygen storage; one labeled "Full" and one "Empty". Observation of the oxygen cylinders stored in each rack revealed one (1) full cylinder and four (4) empty cylinders in the storage rack marked "Full". The "Empty" rack had four (4) cylinders, none of which were labeled "Empty". When asked, at approximately 11:00 AM, the Maintenance Supervisor stated the facility was not aware the empty cylinders were required to be labeled, or that staff had mixed the empty and full cylinders in the storage room.  Actual NFPA standard:  NFPA 99  11.6.5.2 If empty and full cylinders are stored 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		
K 926 SS=D	Gas Equipment - Qualifications and Training CFR(s): NFPA 101  Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the	K 926	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,  Maintenance Director or Designee will audit all cylinders monthly and will report to monthly QAPI meeting for compliance for the duration of 6 months. All identified trends will be addressed through system modification and staff education as appropriate.	

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K 926	<p>Continued From page 3</p> <p>maintenance and operation of equipment. 11.5.2.1 (NFPA 99)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure staff were properly trained on the risks associated with the handling and use of medical gases. Failure to provide an education program which includes periodic review of safety guidelines and usage requirements for medical gases and their cylinders, could hinder staff response, affect those residents utilizing supplemental oxygen and potentially result in a life threatening or catastrophic accident. This deficient practice had the potential to affect 18 oxygen dependent residents and staff on the dates of the survey.</p> <p>Findings include:</p> <p>During the review of facility training records conducted on January 6, 2020, from approximately 12:00 PM to 2:30 PM, no records were available to indicate the facility maintained an ongoing continuing education program for staff which includes periodic review of safety guidelines and usage requirements for medical gases and their cylinders. When asked, on January 7, 2020, at approximately 2:00 PM, the Maintenance Supervisor stated the facility was providing medical gas training for staff required to handle oxygen but could not produce documentation to support the training.</p> <p>Actual NFPA standard:</p> <p>NFPA 99 11.5.2 Gases in Cylinders and Liquefied Gases in Containers.</p>	K 926	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>All employees were educated on the application, maintenance, handling, and risk of medical gases.</p> <p>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;</p> <p>All oxygen dependent residents(18 residents) and staff had the potential to be affected by the deficient practice. All employees were educated on the application, maintenance, handling, and risk of medical gases.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;</p>	

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K 926	Continued From page 4 11.5.2.1 Qualification and Training of Personnel. 11.5.2.1.1* Personnel concerned with the application and maintenance of medical gases and others who handle medical gases and the cylinders that contain the medical gases shall be trained on the risks associated with their handling and use. 11.5.2.1.2 Health care facilities shall provide programs of continuing education for their personnel. 11.5.2.1.3 Continuing education programs shall include periodic review of safety guidelines and usage requirements for medical gases and their cylinders.	K 926	SDC or Designee will provide oxygen handling and use of Medical Gases training during orientation of all new hires.  Maintenance Director or Designee will provide annual education and documentation of safety guidelines and usage requirements for medical gases and cylinders.  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,  Maintenance Director or Designee will randomly audit employees during oxygen handling for the duration of 6 months to ensure compliance was met. Results will be brought to monthly safety meeting. Identified trends will be addressed through system modification and staff education as appropriate.	2/1/2020



IDAHO DEPARTMENT OF  
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January 9, 2020

Jordan Thompson, Administrator  
Valley View Nursing & Rehabilitation  
1140 North Allumbaugh Street  
Boise, ID 83704-8700

Provider #: 135098

**RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER**

Dear Mr. Thompson:

On **January 7, 2020**, an Emergency Preparedness survey was conducted at Valley View Nursing & Rehabilitation 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

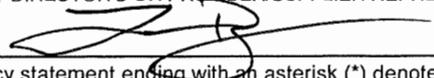
NE/lj  
Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  01/07/2020
NAME OF PROVIDER OR SUPPLIER  VALLEY VIEW NURSING & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1140 NORTH ALLUMBAUGH STREET BOISE, ID 83704		
(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	
E 000	<p>Initial Comments</p> <p>The facility is a two-story Type II (111) construction completed in 1985, with a complete renovation in 2009. There is a two-hour fire separation between the skilled nursing facility and the attached retirement center apartments. The fire alarm system was upgraded in 2009 with addressable smoke detection throughout the building. The fire sprinkler system was also upgraded in 2009 with quick response heads throughout. The facility is currently licensed for 120 SNF/NF beds and had a census of 78 on the dates of the survey.</p> <p>The facility was found to be in substantial compliance during the annual Emergency Preparedness Survey conducted on January 6 - 7, 2020. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73.</p> <p>The Survey was conducted by:</p> <p>Linda Chaney Health Facility Surveyor Facility Fire Safety &amp; Construction</p>	E 000			

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

TITLE

(X6) DATE



ADMINISTRATOR

1/17/2020

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.