



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

May 1, 2019

Dawn Meyer, Administrator
Lincoln County Care Center
PO Box 830
Shoshone, ID 83352-1502

Provider #: 135056

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

Dear Ms. Meyer:

On **April 24, 2019**, a Facility Fire Safety and Construction survey was conducted at **Lincoln County Care Center** 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

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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 **May 14, 2019**. Failure to submit an acceptable PoC by **May 14, 2019**, may result in the imposition of civil monetary penalties by **June 5, 2019**.

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 **May 29, 2019**, (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 **July 23, 2019**. A change in the seriousness of the deficiencies on **June 8, 2019**, 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 29, 2019**, includes the following:

Denial of payment for new admissions effective **July 24, 2019**.
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 **October 24, 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 **April 24, 2019**, 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:

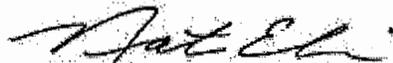
BFS Letters (06/30/11)

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

This request must be received by **May 14, 2019**. If your request for informal dispute resolution is received after **May 14, 2019**, 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: 04/30/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135056	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 04/24/2019
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NAME OF PROVIDER OR SUPPLIER LINCOLN COUNTY CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 511 EAST FOURTH STREET SHOSHONE, ID 83352
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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	INITIAL COMMENTS The facility is a single story, type V(111) construction built in 1958. It is fully sprinklered with an interconnected fire alarm/smoke detection system and offsite monitoring. Backup emergency power is provided by an onsite, spark ignited Emergency Power Supply System (EPSS) generator, that was updated in 2017. There is a partial basement that contains the boiler room, storage, and employee lounge. Currently the facility is licensed for 36 SNF/NF beds, and had a census of 33 on the date of the survey. The following deficiencies were cited during the annual fire/life safety survey conducted on April 24, 2019. The facility was surveyed under the LIFE SAFETY CODE 2012 Edition, Chapter 19, Existing Healthcare Occupancies, in accordance with 42 CFR 483.70. The survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	K 000	RECEIVED MAY 13 2019 FACILITY STANDARDS	
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure means of egress were	K 211		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE
Cheryl Meyer Administrator 5/10/19

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 211	<p>Continued From page 1</p> <p>maintained in accordance with NFPA 101. Failure to ensure doors equipped with delayed egress were signed indicating the function of the system, has the potential to hinder evacuation of residents during an emergency. This deficient practice affected 33 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 4/24/19 from 11:00 AM - 12:00 PM, observation of the main entrance and the west exit door, revealed both were equipped with magnetic locking arrangements. Further observation of these doors established the west door was not equipped with a sign indicating the operation of the delayed egress component of the door.</p> <p>The door on the left side when exiting from the front entrance, was observed to have a conflicting sign to the operation of the delayed egress component, instructing users to "not use this door".</p> <p>Interview of the Maintenance Director established the conflicting sign at the front door was put up to keep staff from using it as a primary exit door.</p> <p>Actual NFPA Standard:</p> <p>7.2.1.6* Special Locking Arrangements. 7.2.1.6.1 Delayed-Egress Locking Systems. 7.2.1.6.1.1 Approved, listed, delayed-egress locking systems shall be permitted to be installed on door assemblies 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</p>	K 211	<p>K211 NFPA 101 Means of Egress, The facility will ensure that all doors equipped with delayed egress, should have signs with instructions of the system.</p> <ol style="list-style-type: none"> 1. Staff in-serviced on the importance of the signs to be in place for all exits, with delayed egress. Signs were ordered for Exit on west end of building. Date ordered 5/7/19, Temporary signage in place until formatted signs are delivered.(see exhibit A) Signage of Left door of front entrance was removed, and staff in-serviced to use red stop sign for resident's with memory loss, to assist in the redirection of using left entry way door. Stop sign was purchased on 5/3/19, and temporary signage is now in place. 2. All residents, staff and visitors have the potential to be affected by this practice. 3. Maintenance Director will audit door signage for all egress with delayed action for proper placement. Monthly started date. 5/7/19 4. All audits will be reviewed in QAPI by administrator. 	5/7/19

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K 211	<p>Continued From page 2</p> <p>9.7, and where permitted in Chapters 11 through 43, provided that all of the following criteria are met:</p> <p>(1) The door leaves shall unlock in the direction of egress upon actuation of one of the following:</p> <p>(a) Approved, supervised automatic sprinkler system in accordance with Section 9.7</p> <p>(b) Not more than one heat detector of an approved, supervised automatic fire detection system in accordance with Section 9.6</p> <p>(c) Not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6</p> <p>(2) The door leaves shall unlock in the direction of egress upon loss of power controlling the lock or locking mechanism.</p> <p>(3)*An irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions:</p> <p>(a) The force shall not be required to exceed 15 lbf (67 N).</p> <p>(b) The force shall not be required to be continuously applied for more than 3 seconds.</p> <p>(c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening.</p> <p>(d) Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only.</p> <p>(4)*A readily visible, durable sign in letters not less than 1 in. (25 mm) high and not less than 1.8 in. (3.2 mm) in stroke width on a contrasting background that reads as follows shall be located on the door leaf adjacent to the release device in the direction of egress: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS</p>	K 211		
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K 211	Continued From page 3 (5) The egress side of doors equipped with delayed-egress locks shall be provided with emergency lighting in accordance with Section 7.9.	K 211		
K 222 SS=F	<p>Egress Doors CFR(s): NFPA 101</p> <p>Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING</p>	K 222		

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K 222	<p>Continued From page 4</p> <p>ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4</p> <p>ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4</p> <p>ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that exit doors were arranged to be readily opened from the egress side. Failure of magnetic locking arrangements to release as designed, could hinder the safe evacuation of residents during an emergency. This deficient practice affected 33 residents, staff and visitors on the date of the survey.</p> <p>Findings Include:</p> <p>During the facility tour on 4/24/19 from 11:00 AM - 12:00 PM, observation of the main entrance door revealed it was equipped with a Wandergaurd</p>	K 222		

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K 222	<p>Continued From page 5</p> <p>magnetic locking arrangement. Operational testing of the exit with the lock magnetic lock engaged, revealed the door on the left hand side when exiting would not release with the designed Delayed Egress component under applied pressure.</p> <p>Interview of the Maintenance Director established he was aware this door was not releasing as designed.</p> <p>Actual NFPA standard:</p> <p>19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side, unless otherwise permitted by one of the following:</p> <p>(1) Locks complying with 19.2.2.2.5 shall be permitted.</p> <p>(2) Delayed-egress locks complying with 7.2.1.6.1 shall be permitted.</p> <p>(3) Access-controlled egress doors complying with 7.2.1.6.2 shall be permitted.</p> <p>(4) Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted.</p> <p>(5) Approved existing door-locking installations shall be permitted</p> <p>7.2.1.6.1 Delayed-Egress Locking Systems.</p> <p>7.2.1.6.1.1 Approved, listed, delayed-egress locking systems shall be permitted to be installed on door assemblies 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 11 through 43, provided that all of the following criteria are met:</p>	K 222	<p>K222 SS=F NFPA 101 Egress Doors</p> <p>The facility will ensure that doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from egress side, unless otherwise permitted by delayed-Egress Locking systems.</p> <ol style="list-style-type: none"> 1. Pinnacle Technologies , were called to repair front exit, and to replace delayed egress Emlock on west hall and east hall exits. Installation of new Emlocks 5/13/19 (exhibit B) Wander guard system was shut down, to allow all exit doors to open freely, with only the alarm system going off. This permits no locking on any exit doors, and all doors open with fire alarm goes off, with or with out wander guard band. 2. All residents have the potential to be affected. 3. Maintenance Director to audit system weekly, for 4 weeks then monthly. All staff in-serviced on the importance of the system working properly, in case of emergency. 4. All audits will be reviewed in QAPI meeting by Administrator and team. 5. All corrective action will be completed on 5/13/19 	5/13/19
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K 222	<p>Continued From page 6</p> <p>(1) The door leaves shall unlock in the direction of egress upon actuation of one of the following:</p> <p>(a) Approved, supervised automatic sprinkler system in accordance with Section 9.7</p> <p>(b) Not more than one heat detector of an approved, supervised automatic fire detection system in accordance with Section 9.6</p> <p>(c) Not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6</p> <p>(2) The door leaves shall unlock in the direction of egress upon loss of power controlling the lock or locking mechanism.</p> <p>(3)*An irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions:</p> <p>(a) The force shall not be required to exceed 15 lbf (67 N).</p> <p>(b) The force shall not be required to be continuously applied for more than 3 seconds.</p> <p>(c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening.</p> <p>(d) Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only.</p> <p>(4)*A readily visible, durable sign in letters not less than 1 in. (25 mm) high and not less than 1.8 in. (3.2 mm) in stroke width on a contrasting background that reads as follows shall be located on the door leaf adjacent to the release device in the direction of egress: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS</p> <p>(5) The egress side of doors equipped with delayed-egress locks shall be provided with emergency lighting in accordance with Section</p>	K 222		

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K 222	Continued From page 7 7.9.	K 222		
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 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 and interview, the facility failed to ensure that fire suppression systems were maintained in accordance with NFPA 25. Failure to inspect suppression system components has the potential to hinder system performance during a fire event and/or render the facility not fully sprinklered after an activation or repair. This deficient practice affected 33 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 4/24/19 from 8:30 -</p>	K 353	<p>K353 SS=F NFPA 25 Sprinkler Maintenance and testing, Waterflow devices</p> <p>The Facility will ensure that Waterflow Alarm Devices are checked and monitored on a Quarterly bases.</p> <ol style="list-style-type: none"> Maintenance director was in-serviced to perform test on 5/10/19 to ensure system is functioning correctly. Maintenance to perform test quarterly, to comply with requirement and logs to be kept in Fire Life Safety Manuel. All staff in-serviced on Life safety code. All residents, visitors and staff have the potential to be effected. Maintenance Director to bring monitoring form to QAPI meeting for Administrator to sign completion of task. All documentation to be reviewed in QAPI meeting. All tasks completed on 5/10/19 (see exhibit C) 	5/10/19

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K 353	Continued From page 8 11:00 AM, no documentation was available demonstrating completion of quarterly waterflow alarm tests for 3 of 4 quarters between 2018 and 2019. Interview of the Maintenance Supervisor revealed he was not aware of the missing documentation prior to the date of the survey. Actual NFPA standard: NFPA 25 5.3.3 Waterflow Alarm Devices. 5.3.3.1 Mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly.	K 353		
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no	K 363		

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K 363	<p>Continued From page 9</p> <p>impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.</p> <p>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485</p> <p>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, the facility failed to ensure doors entering into a means of egress corridor would resist the passage of smoke and fire. Installation of transfer grilles into doors housing combustible materials, has the potential to allow smoke, fire and dangerous gases to pass between compartments and effect the egress of occupants during a fire. This deficient practice affected staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 4/24/2019 from 1:00 - 2:00 PM, observation of three storage rooms in the basement level, revealed they housed medical records, activities storage and the facility water heaters. Further observation of the doors entering these spaces from the corridor, revealed all three were equipped with</p>	K 363	<p>K363 SS= D Corridor Doors Transfer Grilles</p> <p>The facility will ensure that doors entering into means of egress corridor will resist the passage of smoke, and fire.</p> <ol style="list-style-type: none"> 1. The three doors were capped, with wood to grill openings. An inspection of all remaining doors in the building to ensure that there was no other doors with grills in the building. 2. All resident, staff and visitors have the potential to be affected by this practice. 3. All doors will be inspected annually for damage, and proper placement, by Maintenance Director. 4. All audits will be reviewed in QAPI for completion, by Administrator. 5. All actions will be completed by 5/10/19 (see exhibit D) 	5/10/19

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K 363	Continued From page 10 louvered transfer grilles cut into the doors, approximately 24 inches wide by 8 inches in height. Actual NFPA standard: 19.3.6.4 Transfer Grilles. 19.3.6.4.1 Transfer grilles, regardless of whether they are protected by fusible link-operated dampers, shall not be used in corridor walls or doors.	K 363	K511 SS= D NFPA 70 Installation and use , Relocatable Power Taps The facility will ensure that relocatable power taps will not be used on large appliances or equipment. 1. The outlet in the hot water heater room, was rewired by a electrician, on 5/6/19. (see exhibit F) Maintenance Director to do a inspection of all Large appliance to ensure no RPT are not in use. All staff in-serviced on the Life Safety code for use of RPT.	5/10/19
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure approved and safe electrical installations were in accordance with NFPA 70 and listed assemblies. Use of relocatable power taps (RPT) with large appliances or equipment not within its listed assembly, has been historically linked to arc fires in facilities. This deficient practice potentially affected staff and visitors on the date of the survey. Findings include:	K 511	2. All Staff and residents have the potential to be affected by this practice. 3. Monthly audit by Maintenance Director of building for possible use of RPT 4. All audit to reviewed in QAPI and administrator to review. 5. All audits to be completed by 5/10/19	

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K 511	<p>Continued From page 11</p> <p>During the facility tour conducted on 4/24/19 from 1:00 - 2:00 PM, observation of the basement water heater area, revealed the facility was using a RPT to supply power from the outlet to two (2) recirculating pumps for the hot water supply system.</p> <p>Actual NFPA standard:</p> <p>NFPA 70</p> <p>110.2 Approval. The conductors and equipment required or permitted by this Code shall be acceptable only if approved. Informational Note: See 90.7, Examination of Equipment for Safety, and 110.3, Examination, Identification, Installation, and Use of Equipment. See definitions of Approved, Identified, Labeled, and Listed.</p> <p>110.3 Examination, Identification, Installation, and Use of Equipment. (A) Examination. In judging equipment, considerations such as the following shall be evaluated: (1) Suitability for installation and use in conformity with the provisions of this Code Informational Note: Suitability of equipment use may be identified by a description marked on or provided with a product to identify the suitability of the product for a specific purpose, environment, or application. Special conditions of use or other limitations and other pertinent information may be marked on the equipment, included in the product instructions, or included in the appropriate listing and labeling information. Suitability of equipment may be evidenced by listing or labeling. (2) Mechanical strength and durability, including, for parts designed to enclose and protect other equipment, the adequacy of the protection thus</p>	K 511		
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K 511	Continued From page 12 provided (3) Wire-bending and connection space (4) Electrical insulation (5) Heating effects under normal conditions of use and also under abnormal conditions likely to arise in service (6) Arcing effects (7) Classification by type, size, voltage, current capacity, and specific use (8) Other factors that contribute to the practical safeguarding of persons using or likely to come in contact with the equipment (B) Installation and Use. Listed or labeled equipment shall be installed and used in accordance with any instructions included in the listing or labeling. Additional reference: UL 1363 Standard for Relocatable Power Taps	K 511		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility	K 712		

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K 712	<p>Continued From page 13</p> <p>failed to ensure fire drills were conducted in accordance with NFPA 101. Failure to perform fire drills quarterly for each shift has the potential to hinder staff response in the event of a fire. This deficient practice affected 33 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During review of provided facility maintenance records conducted on 4/24/19 from 8:45 - 10:30 AM, records revealed the facility had missed the fire drills for the swing shift during the first quarter of 2019 and third quarter of 2018.</p> <p>Interview of the Maintenance Director revealed he was unaware the facility had missed fire drills.</p> <p>Actual NFPA standard:</p> <p>19.7* Operating Features.</p> <p>19.7.1 Evacuation and Relocation Plan and Fire Drills.</p> <p>19.7.1.6 Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions.</p>	K 712	<p>K712 SS=F NFPA 101 Fire Drills</p> <p>The facility will ensure that all fire drills will be performed each shift per quarter.</p> <ol style="list-style-type: none"> 1. Maintenance to maintain a log book of fire drills. All staff in-serviced on procedure for the drills, and that each shift has to have a drill in the quarter. Silent alarm drills can not take place before 10pm. 2. All residents have the potential to be affected by this practice. 3. All fire drills will be audited for compliance each month, by Administrator.. 4. All audits and fire drills will be reviewed during QAPI 5. Completed by 5/10/19 (see exhibit G) 	5/10/19
K 761 SS=E	<p>Maintenance, Inspection & Testing - Doors</p> <p>CFR(s): NFPA 101</p> <p>Maintenance, Inspection & Testing - Doors</p> <p>Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility</p>	K 761		

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K 761	<p>Continued From page 14 maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure that drop-down fire door assemblies were inspected and tested at least annually in accordance with NFPA 80. Failure to test drop-down doors has the potential to hinder system performance and allow smoke, fire and dangerous gases to pass between compartments during a fire event. This deficient practice affected residents, staff and visitors occupying the main dining room on the date of the survey.</p> <p>Findings include:</p> <p>During review of facility maintenance and inspection records conducted on 4/24/19 from 8:45 - 10:30 AM, no records were available indicating an annual test of the drop-down door assembly at the pass-thru window to the Kitchen had been conducted.</p> <p>During the facility tour conducted on 4/24/19 from 11:00 AM - 2:00 PM, observation of the pass-thru door to the dishwashing area of the main Kitchen, revealed this door was labeled in accordance with the 1-hour assembly of the Kitchen hazardous area and a NFPA 80 testing document. It was also observed to have both an automatic electrical activation and fusible link activated closure.</p>	K 761		
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K 761	<p>Continued From page 15</p> <p>When asked if the drop-down door had been tested on an annual basis, the Maintenance Director stated he was not aware of the requirement to test the door prior to the survey.</p> <p>Actual NFPA standard:</p> <p>19.7.6 Maintenance and Testing. See 4.6.12.</p> <p>4.6.12 Maintenance, Inspection, and Testing. 4.6.12.1 Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, fire-resistive construction, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, fire-resistive construction, or other feature shall thereafter be continuously maintained. Maintenance shall be provided in accordance with applicable NFPA requirements or requirements developed as part of a performance-based design, or as directed by the authority having jurisdiction.</p> <p>8.3.3 Fire Doors and Windows. 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code.</p> <p>NFPA 80 Chapter 5 Care and Maintenance 5.2* Inspections.</p>	K 761	<p>K761 SS=E NFPA 80 Care and Maintenance inspection of fire door assemblies</p> <p>The facility will ensure that all fire door assemble shall be inspected and ested annually.</p> <ol style="list-style-type: none"> 1. The drop down door was added to the inspection list for all fire door assemblies. All fire door assemblies were inspected, to be assured that they were in functional order. (see exhibit H) on 5/10/19 2. All residents and staff have the potential to be affected by this practice. 3. All fire doors will be assessed annually and PRN for any damage or concerns. 4. All audits will be reviewed in QAPI. 5. All audits will be completed by 5/13/19 	5/13/19
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K 761	Continued From page 16 5.2.1* Fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. 5.2.3 Functional Testing. 5.2.3.1 Functional testing of fire door and window assemblies shall be performed by individuals with knowledge and understanding of the operating components of the type of door being subject to testing.	K 761		
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure resident room electrical receptacles were maintained in accordance with	K 914	K914 SS=F NFPA 99 Electrical Systems The facility will ensure that all outlets will be tested annually for physical integrity, continuity of grounding circuit, correct polarity of hot and neutral connections, and retention force of grounding blade of each electrical receptacle,(except locking-type receptacles) shall be not less than 115g (4oz) 1. The maintenance department set up an audit tool, for auditing all outlets with 4 components of testing. (completed 5/10/19) A 2. This has the potential to affect all residents. 3. Receptacle tension tester was ordered to assist with completing the testing. One was borrowed from local electrician. 4. Maintenance Director will bring all audits for review in QAPI meeting, to be assessed for compliance with Life Safety requirements. 5. All audits to be completed 5/13/19	5/13/19

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K 914	<p>Continued From page 17</p> <p>NFPA 99. Failure to test patient room electrical receptacles annually has the potential to hinder system response during an emergency that encompasses a loss of power. This deficient practice affected 33 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During review of provided maintenance documents conducted on 4/24/19 from 8:45 - 10:30 AM, records provided for the annual testing of resident room outlets indicated the outlets were "inspected", but no documentation as to what functions or conditions these outlets were tested for during that inspection.</p> <p>Interview of the Maintenance Supervisor established he was not aware of the requirements to document testing of outlets on an annual basis.</p> <p>Actual NFPA standard:</p> <p>NFPA 99 Chapter 6 Electrical Systems</p> <p>6.3.3.2 Receptacle Testing in Patient Care Rooms.</p> <p>6.3.3.2.1 The physical integrity of each receptacle shall be confirmed by visual inspection.</p> <p>6.3.3.2.2 The continuity of the grounding circuit in each electrical receptacle shall be verified.</p> <p>6.3.3.2.3 Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed.</p> <p>6.3.3.2.4 The retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 g (4 oz).</p>	K 914		
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K 914	Continued From page 18 6.3.4.1 Maintenance and Testing of Electrical System. 6.3.4.1.1 Where hospital-grade receptacles are required at patient bed locations and in locations where deep sedation or general anesthesia is administered, testing shall be performed after initial installation, replacement, or servicing of the device. 6.3.4.1.2 Additional testing of receptacles in patient care rooms shall be performed at intervals defined by documented performance data. 6.3.4.1.3 Receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months.	K 914		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135056	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 04/24/2019
NAME OF PROVIDER OR SUPPLIER LINCOLN COUNTY CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 511 EAST FOURTH STREET SHOSHONE, ID 83352		
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C 000	<p>INITIAL COMMENTS</p> <p>The facility is a single story, type V(111) construction built in 1958. It is fully sprinklered with an interconnected fire alarm/smoke detection system and offsite monitoring. Backup emergency power is provided by an onsite, spark ignited Emergency Power Supply System (EPSS) generator, that was updated in 2017. There is a partial basement that contains the boiler room, storage, and employee lounge. Currently the facility is licensed for 36 SNF/NF beds, and had a census of 33 on the date of the survey.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on April 24, 2019. The facility was surveyed under IDAPA 16.03.02, Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities and the LIFE SAFETY CODE 2012 Edition, Chapter 19, 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 and Construction</p>	C 000	<p>C260 Weekly Cleaning of Range Hoods/filters</p> <p>All range hoods and filters shall be cleaned at least weekly.</p> <ol style="list-style-type: none"> 1. Corrective actions: All resident were observed and assessed for any concerns with the Hood not having cleaning schedule documented. 2. All residents have the potential to be affected by the deficient practice. 3. All Dietary staff were in-serviced to document each time the Hood has been cleaned, and the need for weekly cleaning. Weekly cleaning documentation was added to cleaning audit for kitchen. 4. Dietary manager will audit cleaning schedule weekly, to ensure practice is completed. 5. All audits will be reviewed in QAPI for compliance. All in-services and audits to be completed by 5/7/19 	5/7/19
C 260	<p>02.106.07,h Weekly Cleaning of Range Hoods/Filters</p> <p>h. All range hoods and filters shall be cleaned at least weekly. This RULE: is not met as evidenced by: Based on observation and interview, the facility failed to ensure that kitchen hood filters were cleaned on a weekly basis. Failure to clean hood filters weekly has the potential for grease fire due to excessive grease build-up. This deficient practice affected staff and visitors of the main</p>	C 260	<p style="text-align: center;">RECEIVED</p> <p style="text-align: center;">MAY 13 2019</p> <p style="text-align: center;">FACILITY STANDARDS</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

TITLE

(X6) DATE

Dawn Meyer Administrator

5/7/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135056	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 04/24/2019
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NAME OF PROVIDER OR SUPPLIER LINCOLN COUNTY CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 511 EAST FOURTH STREET SHOSHONE, ID 83352
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C 260	<p>Continued From Page 1</p> <p>Kitchen on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 4/24/19 from 1:00 - 2:00 PM, observation of the weekly cleaning schedule posted in the main Kitchen, did not indicate a schedule for weekly cleaning of the hood filters. When asked about the cleaning of the hood filters, the Dietary Manager stated this was a routine cleaning procedure, but was not on the schedule and there was no documentation demonstrating this procedure was performed weekly.</p> <p>Actual IDAPA standard:</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.</p> <p>07. Maintenance of Equipment. The facility shall establish routine test, check and maintenance procedures for all equipment.</p> <p>h. All range hoods and filters shall be cleaned at least weekly.</p>	C 260		
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If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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

May 1, 2019

Dawn Meyer, Administrator
Lincoln County Care Center
PO Box 830
Shoshone, ID 83352-1502

Provider #: 135056

RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER

Dear Ms. Meyer:

On **April 24, 2019**, an Emergency Preparedness survey was conducted at Lincoln County Care Center 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: 135056	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/24/2019
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NAME OF PROVIDER OR SUPPLIER LINCOLN COUNTY CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 511 EAST FOURTH STREET SHOSHONE, ID 83352
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E 000	<p>Initial Comments</p> <p>The facility is a single story, type V(111) construction built in 1958 and is located within a rural fire district with both state and county EMS services available. Backup emergency power is provided by an onsite, spark ignited Emergency Power Supply System (EPSS) generator, that was updated in 2017. It is fully sprinklered with an interconnected fire alarm/smoke detection system and offsite monitoring. There is a partial basement that contains the boiler room, storage, and employee lounge. Currently the facility is licensed for 36 SNF/NF beds, and had a census of 33 on the date of the survey.</p> <p>The facility was found to be in substantial compliance during the Emergency Preparedness Survey conducted on April 24, 2019. 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>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	E 000	<p>RECEIVED</p> <p>MAY 13 2019</p> <p>FACILITY STANDARDS</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Clara Meyer</i>	TITLE <i>Administrator</i>	(X6) DATE <i>5/10/19</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting if 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.