



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 10, 2019

Jason Jensen, Administrator
Bingham Memorial Skilled Nursing & Rehabilitation
98 Poplar Street
Blackfoot, ID 83221-1758

Provider #: 135007

RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER

Dear Mr. Jensen:

On **May 1, 2019**, an Emergency Preparedness survey was conducted at **Bingham Memorial Skilled Nursing & Rehabilitation** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with 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. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. Please provide **ONLY ONE** completion date for each federal and state tag in column (X5) Completion Date to signify when you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **May 23, 2019**. Failure to submit an acceptable PoC by **May 23, 2019**, may result in the imposition of civil monetary penalties by **June 14, 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 **June 5, 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 . A change in the seriousness of the deficiencies on **June 24, 2019**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **June 5, 2019**, includes the following:

Denial of payment for new admissions effective **August 1, 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 **November 1, 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 **May 1, 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:

<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)

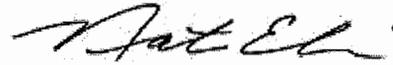
2001-10 Long Term Care Informal Dispute Resolution Process
2001-10 IDR Request Form

Jason Jensen, Administrator
May 10, 2019
Page 4 of 4

This request must be received by **May 23, 2019**. If your request for informal dispute resolution is received after **May 23, 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: 05/09/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/01/2019
NAME OF PROVIDER OR SUPPLIER BINGHAM MEMORIAL SKILLED NURSING & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 98 POPLAR STREET BLACKFOOT, ID 83221	
(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	Initial Comments The facility is a single-story, type V (III) structure with a partial basement utilized for mechanical/electrical rooms, storage, offices and classrooms. A two-hour fire wall separates the skilled nursing facility from the JCAHO accredited hospital at every point the two meet. The facility was originally built in 1963 with a renovation and addition in 1999. The building is fully sprinklered and is protected by a complete fire alarm system with smoke detection in corridors and open spaces. The Essential Electrical System is supplied by a diesel powered, on-site automatic generator. The facility is currently licensed for 60 SNF/NF beds and had a census of 40 on the dates of the survey. The following deficiencies were cited during the emergency preparedness survey conducted on April 30 - May 1, 2019. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73. The Survey was conducted by: Linda Chaney Health Facility Surveyor Facility Fire Safety and Construction	E 000	This plan of correction is submitted by the facility in accordance with the pertinent terms of provisions of 42CFR Section 488 and/or related state regulations, and is intended to serve as a credible allegation of our intent to correct the practices identified as deficient. The Plan of Correction should not be construed or interpreted as an admission that the deficiencies alleged did, in fact, exist; rather, the facility is filing this document in order to comply with its obligations as provider participating in the Medicare/ Medicaid program(s).	
E 006 SS=F	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (1) Be based on and include a documented,	E 006	RECEIVED MAY 23 2019 FACILITY STANDARDS E 006 All patients, staff, and visitors have the potential to be affected.	5/31/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE Administrator (X6) DATE 5/22/19

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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NAME OF PROVIDER OR SUPPLIER BINGHAM MEMORIAL SKILLED NURSING & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 98 POPLAR STREET BLACKFOOT, ID 83221	
(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 006	<p>Continued From page 1 facility-based and community-based risk assessment, utilizing an all-hazards approach.*</p> <p>*[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents.</p> <p>*[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients.</p> <p>(2) Include strategies for addressing emergency events identified by the risk assessment.</p> <p>* [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to conduct a comprehensive facility-based and community-based risk assessment to include strategies for addressing emergency events identified by the risk assessment. Failure to conduct a facility and community-based risk assessment with strategies for response hinders the facility's ability to respond to localized disasters and emergencies. This deficient practice affected 40 residents, staff and visitors on the dates of the survey.</p> <p>Findings include:</p>	E 006	<p>Root-cause analysis revealed lack of continuity in the risk assessment to include the identified hazards in the Hazard Vulnerability Assessment (HVA).</p> <p>We believe education/training is the best prevention. Members of the Emergency Planning Committee were educated and trained on comprehensive facility-based and community-based risk assessments and for properly addressing emergency events identified through the HVA all have strategies for response.</p> <p>We will maintain this through annual review of the HVA, facility- based and community-based risk assessments to make sure all identified hazards are in the Emergency Program (EP) and the HVA. Similar issues with similar processes will be condensed.</p> <p>Audit of this 1 week after Emergency Planning Committee meeting to make sure all identified risks are addressed through the EP and HVA with strategies for response.</p> <p>Areas of concern will be addressed immediately and discussed at QA (Quality Assurance) meeting, monthly and PRN.</p> <p>Date of Completion May 31, 2019</p>	5/31/19

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NAME OF PROVIDER OR SUPPLIER BINGHAM MEMORIAL SKILLED NURSING & REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 98 POPLAR STREET BLACKFOOT, ID 83221		
(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 006	Continued From page 2 On April 30, 2019, from approximately 1:00 PM to 4:30 PM, review of the provided emergency preparedness plan, including the facility Hazard Vulnerability Assessment (HVA) revealed some of the hazards identified on the HVA did not have strategies for response. They were; Severe Thunderstorm, Drought, Tornado, Snowfall, Blizzard, Ice Storm, Dam Inundation, Structural Damage, Medical Gas Failure, Supply shortage, Steam Failure, Transportation Failure, Sewer Failure, Medical Vacuum Failure, Fuel Shortage, Mass Casualty- medical/infectious, Infant Abduction, Mass Casualty - Trauma, Forensic Admission, Terrorism, Biological, Civil Disturbance, Hostage Situation, Labor Action, Chemical Exposure - External, Small-Medium Internal Spill, Terrorism - Chemical, Radiologic Exposure - Internal, Radiologic Exposure - External, Terrorism - Radiologic, Large Internal Spill. Additionally, some strategies for response were in the EP plan, but not listed on the HVA. They were; Active Shooter/Armed Intruder, Emergency Admits (Surge). When asked, the Administrator and Nurse assigned to Emergency Preparedness stated the facility was not aware of the discrepancies on the HVA. Reference: 42 CFR 483.73 (a) (1) - (2) Integrated EP Program CFR(s): 483.73(f) (e) [or (f)]Integrated healthcare systems. If a [facility] is part of a healthcare system consisting of multiple separately certified healthcare facilities that elects to have a unified and integrated emergency preparedness program, the [facility]	E 006		
E 042 SS=F		E 042	E 042 All patients, staff, and visitors have the potential to be affected.	5/31/19

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NAME OF PROVIDER OR SUPPLIER BINGHAM MEMORIAL SKILLED NURSING & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 98 POPLAR STREET BLACKFOOT, ID 83221	
(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 042	<p>Continued From page 4</p> <p>(b) of this section, a coordinated communication plan, and training and testing programs that meet the requirements of paragraphs (c) and (d) of this section, respectively.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to demonstrate compliance with the requirements to participate in a unified and integrated health systems' emergency preparedness program. Failure to meet all the requirements for participation, has the potential to impede communication, incumber coordination of training and hinder staff response during a disaster. This deficient practice affected 40 residents, staff and visitors on the dates of the survey.</p> <p>Findings include:</p> <p>On April 30, 2019, from approximately 1:00 PM to 4:30 PM, review of the provided emergency preparedness plan, policies and procedures revealed the facility was one (1) of three (3) facilities, each separately certified as a Medicare-participating provider in a unified and integrated healthcare system. The facilities were identified as:</p> <ol style="list-style-type: none"> 1.) Bingham Memorial Hospital 2.) Bingham Memorial Skilled Nursing and Rehabilitation Center 3.) Bingham Memorial New Leaf Geriatric Psychiatric Unit <p>These facilities had developed a unified and integrated emergency preparedness program that included all of the facilities within the healthcare system. However, documentation could not be</p>	E 042	<p>Areas of concern will be addressed immediately and discussed at QA (Quality Assurance) meeting, monthly and PRN.</p> <p>Date of Completion May 31, 2019</p>	5/31/19

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/01/2019
NAME OF PROVIDER OR SUPPLIER BINGHAM MEMORIAL SKILLED NURSING & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 98 POPLAR STREET BLACKFOOT, ID 83221	
(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 042	Continued From page 3 may choose to participate in the healthcare system's coordinated emergency preparedness program. If elected, the unified and integrated emergency preparedness program must- [do all of the following:] (1) Demonstrate that each separately certified facility within the system actively participated in the development of the unified and integrated emergency preparedness program. (2) Be developed and maintained in a manner that takes into account each separately certified facility's unique circumstances, patient populations, and services offered. (3) Demonstrate that each separately certified facility is capable of actively using the unified and integrated emergency preparedness program and is in compliance [with the program]. (4) Include a unified and integrated emergency plan that meets the requirements of paragraphs (a)(2), (3), and (4) of this section. The unified and integrated emergency plan must also be based on and include the following: (i) A documented community-based risk assessment, utilizing an all-hazards approach. (ii) A documented individual facility-based risk assessment for each separately certified facility within the health system, utilizing an all-hazards approach. (5) Include integrated policies and procedures that meet the requirements set forth in paragraph	E 042	Root-cause analysis revealed lack of evidence showing a representative from each of the 3 identified facilities participated in development and updates of the program. Also lack of evidence/understanding of identifying each facilities unique circumstances due to different patient populations and services. Also a lack of evidence of each facility having a separate facility based risk assessment unique to each facilities hazards. We believe education/training is the best prevention. Members of the Emergency Planning Committee were educated and trained on identifying each facilities unique circumstances due to different patient populations and services. Also having a separate facility based risk assessment unique to each facilities hazards. This will include a coordinated communication plan (training and testing) to meet all of the specific requirements of each facility type. We will maintain this by annual review of the HVA, facility- based and community-based risk assessments to make sure all identified hazards are in the Emergency Program (EP) and the HVA. Similar issues with similar processes will be condensed. Audit of this 1 week after Emergency Planning Committee meeting to make sure all identified.	5/31/19

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NAME OF PROVIDER OR SUPPLIER BINGHAM MEMORIAL SKILLED NURSING & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 98 POPLAR STREET BLACKFOOT, ID 83221	
(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 042	<p>Continued From page 5</p> <p>provided to demonstrate each separately certified facility actively participated in the development and subsequent review and updates of the program. Nor did it address unique circumstances, patient populations and services offered at each facility. Additionally, a facility-based risk assessment had not been developed for each separate entity, taking into consideration facility specific hazards unique to each facility as required.</p> <p>The unified and integrated emergency preparedness program did not include a coordinated communication plan or training and testing program designed to meet all of the specific requirements for each facility type. Interview of the Administrator and the Nurse assigned to Emergency Preparedness revealed the facility was currently part of and desired to continue participation in a unified and integrated emergency preparedness program but was unaware of the specific requirements.</p> <p>Reference: 42 CFR 441.184(e)</p>	E 042		



IDAHO DEPARTMENT OF
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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 10, 2019

Jason Jensen, Administrator
Bingham Memorial Skilled Nursing & Rehabilitation
98 Poplar Street
Blackfoot, ID 83221-1758

Provider #: 135007

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Mr. Jensen:

On **May 1, 2019**, a Facility Fire Safety and Construction survey was conducted at Bingham Memorial Skilled Nursing & Rehabilitation by the Bureau of Facility Standards/Department of Health & Welfare 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. 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

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

PRINTED: 05/09/2019
FORM APPROVED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135007	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE NF B. WING _____		(X3) DATE SURVEY COMPLETED 05/01/2019
NAME OF PROVIDER OR SUPPLIER BINGHAM MEMORIAL SKILLED NURSING & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 98 POPLAR STREET BLACKFOOT, ID 83221		
(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	<p>INITIAL COMMENTS</p> <p>The facility is a single-story, type V (III) structure with a partial basement utilized for mechanical/electrical rooms, storage, offices and classrooms. A two-hour fire wall separates the skilled nursing facility from the JCAHO accredited hospital at every point the two meet. The facility was originally built in 1963 with a renovation and addition in 1999. The building is fully sprinklered and is protected by a complete fire alarm system with smoke detection in corridors and open spaces. The Essential Electrical System is supplied by a diesel powered, on-site automatic generator. The facility is currently licensed for 60 SNF/NF beds and had a census of 40 on the dates of the survey.</p> <p>The facility was found to be in substantial compliance during the annual fire/life safety survey conducted on April 30 - May 1, 2019. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.</p> <p>The Survey was conducted by:</p> <p>Linda Chaney Health Facility Surveyor Facility Fire Safety & Construction</p>	K 000			

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

TITLE

(X6) DATE

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.