STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535042	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/29/2020**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEPHERD OF THE VALLEY REHABILITION AND WELLNESS	**60 MAGNOLIA** **CASPER, WY 82604**

(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 A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on January 28-29, 2020. Requirements for Long Term Nursing Homes Section 42 CFR 483.70 (a) except as otherwise provided in the section, the facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code, Existing Health Care of the National Fire Protection Association. The facility (west and central wing) was a fully sprinklered, one story building with a partial basement of Type V (000) and Type V (111) construction built in 1958 and 1987. The building was equipped with a supervised automatic wet sprinkler system (west wing) and dry sprinkler system (central wing) with an addressable fire alarm system. The facility had 192 certified Medicare and Medicaid beds with a census of 138 residents. .	K 000		
K 211 SS=E	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 staff interview, the facility failed to maintain means of egress in	K 211	This plan of correction is prepared and submitted as required by law. By	3/5/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 02/23/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535042	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/29/2020**

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K 211	Continued From page 1 accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain means of egress as required could delay egress resulting in injury or death during an emergency. The deficiencies affected three (3) of numerous exits from the facility. The findings were: 1. Observation on 1/28/2020 at 4:22 PM at the north secured unit exit revealed the sidewalk covered with snow. Interview with the facility maintenance staff at the time of observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.7.3.1; 7.1.10.1 2. Observation on 1/28/2020 at 1:10 PM in the south dining room revealed an exterior exit door that when tested required more than 30 pounds of force to set the door in motion. Interview with the facility maintenance staff at the time of observation acknowledged the door exceeded 30 pounds of force to open, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.2.2.2.1; 7.2.1.4.5 3. Observation on 1/28/2020 at 4:38 PM in the associates room revealed an exterior exit door	K 211	submitting this plan of correction, Shepherd of the Valley Rehabilitation and Wellness Center does not admit that the deficiency listed on this form exists, nor does the center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiency. The center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts and conclusions that form the basis for the deficiency. 1. The facility will ensure that aisles, passageways, corridors, exit discharges, exit locations and accesses are in accordance with Chapter 7, and the means of egress is continually maintained free of all obstructions to full use in case of emergency unless other wise modified by other NFPA notations. This will be accomplished by: 1.Snow was immediately removed from the North secured unit exit. 2. The South Dining Room exterior door has been adjusted to not require an excess of 30 lbs of pressure to open. 3. The associates room size/space does not require an exit. All features identifying the door as an exit have been removed. 4. The mural on the Secure unit door has been painted over. 5. Exit sidewalks have been audited to ensure there is no snow. Exit doors have been audited to ensure there is no excess poundage of 30 lbs pressure to open them and no murals or obstructive paintings present. 5. The Administrator or designee has educated maintenance staff to the	

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K 211	Continued From page 2 that would not open without putting in a code. According to maintenance staff the door was supposed to alarm and open, but it failed during multiple tests. Interview with the facility maintenance staff at the time of observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Section: 19.2.2.2.4 4. Observation on 1/28/2020 at 5:05 PM in the secured memory care unit revealed an exit door fully covered in a mural of a bookcase which obstructed the visibility of the exit. Interview with the facility maintenance staff at the time of observation acknowledged the deficiency, and indicated they were unaware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Section: 7.1.10.2.1 .	K 211	deficiency. 6. Maintenance Director or designee will randomly audit 5 exits per week x a minimum of 3 months to ensure there is no snow on the sidewalk. 7. Maintenance Director or designee will randomly audit 5 egress doors each week x a minimum of 3 months to ensure that there is no more than 30 lbs of pressure required to open the door and take immediate action should such be noted. 8. Maintenance Director or designee will randomly audit 5 exit doors each week x a minimum of 3 months to ensure there are no paintings or postings covering the door and make immediate corrections if noted. 9. Results of audits will be reviewed at monthly QAPI meetings each month for a minimum of 3 months to address findings and determine continuation.	
K 222 SS=D	Egress Doors CFR(s): NFPA 101 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:	K 222		3/5/20

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K 222	Continued From page 3 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 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 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS	K 222		

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K 222	Continued From page 4 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 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 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain egress doors in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain egress doors as required could result in injury or death during an emergency. The deficiency affected two (2) of numerous exits from the facility. The findings were: Observation on 1/28/2020 at 1:30 PM at the west mechanical exit revealed that the door was provided with delayed-egress hardware, and that delayed-egress signage was not provided to describe delayed-egress operation. Interview with the facility maintenance staff at the time of observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.2.2.2.4(2); 7.2.1.6.1.1(4)	K 222	This plan of correction is prepared and submitted as required by law. By submitting this plan of correction, Shepherd of the Valley Rehabilitation and Wellness Center does not admit that the deficiency listed on this form exists, nor does the center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiency. The center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts and conclusions that form the basis for the deficiency. The facility will ensure that means of egress shall not be equipped with a latch or a lock that requires the use of a tool or a key. This will be accomplished by: 1. Delayed egress signage has been placed on the West mechanical door. 2. All delayed egress doors have been audited to ensure proper signage. 3. Administrator has educated the maintenance staff to the deficiency.	

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K 222	Continued From page 5 .	K 222	4. Maintenance Director or designee will conduct a random weekly audit of 5 egress doors x a minimum of 3 months to ensure proper delayed-egress signage is in place and make immediate correction should such be noted. 5. Results of audits will be reviewed monthly at QAPI meeting to address findings and determine continuation.	
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install the fire sprinkler system in accordance with the 2012 NFPA 101, Life Safety Code and the 2010 NFPA 13, Standard for the Installation of Sprinkler Systems. Failure to install	K 351	This plan of correction is prepared and submitted as required by law. By submitting this plan of correction, Shepherd of the Valley Rehabilitation and Wellness Center does not admit that the	3/5/20

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K 351	Continued From page 6 fire sprinkler systems as required could result in injury or death during an emergency. The deficiency affected less than 10 percent of the facility. The findings were: Observation on 1/28/2020 at 12:56 PM in the hallway adjacent to room 14 revealed a sprinkler head missing an escutcheon. Interview with the facility maintenance manager at the time of observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.3.5.1; 9.7.1.1 2010 NFPA 13, Section: 6.2.7 .	K 351	deficiency listed on this form exists, nor does the center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiency. The center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts and conclusions that form the basis for the deficiency. The facility will ensure the fire sprinkler system is properly installed. This will be accomplished by: 1. The sprinkler head escutcheon has been replaced in the hallway adjacent to room 114. 2. An audit of all sprinkler heads has been conducted to ensure escutcheon's are in place. 3. Administrator has educated the maintenance staff to the deficiency. 4. Maintenance Director or designee will conduct weekly audits of 20 random spaces x a minimum of 3 months to ensure proper installation of sprinkler head escutcheon's and make immediate corrective action for noted deficiency. 5.Results of audits will be reviewed at monthly QAPI x a minimum of 3 months to address findings and determine continuation.	
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 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	K 353		3/5/20

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K 353	Continued From page 7 Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ 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 observation and staff interview, the facility failed to maintain fire sprinkler systems in accordance with the 2012 NFPA 101, Life Safety Code, and the 2011 NFPA 25, Standard for the Inspection, Testing and Maintenance of Water-Based Protection Systems. Failure to maintain fire sprinkler systems as required could result in injury or death during an emergency. The deficiencies affected three (3) of numerous rooms in the facility. The findings were: 1. Observation on 1/28/2020 at 2:12 PM at the main entrance vestibule revealed a lighting fixture obstructing the fire sprinkler head. Further observation in the closet in room 100 revealed a large cardboard box stored within 18 inches of the fire sprinkler head, which obstructed the spray pattern of the sprinkler. Interview with the facility maintenance staff at the time of observation acknowledged the deficiencies, and indicated awareness of the requirement.	K 353	This plan of correction is prepared and submitted as required by law. By submitting this plan of correction, Shepherd of the Valley Rehabilitation and Wellness Center does not admit that the deficiency listed on this form exists, nor does the center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiency. The center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts and conclusions that form the basis for the deficiency. The facility will ensure the fire sprinkler system is properly maintained. This will be accomplished by: 1. The light fixture in the main entrance has been relocated to ensure the sprinkler head is not obstructed. 2. The large cardboard box in the closet in room 100 has been removed to ensure the sprinkler head is not obstructed.	

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K 353	Continued From page 8 Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.3.5.1; 9.7.5 2011 NFPA 25, Section: 5.2.1.2 2. Observation on 1/28/2020 at 12:43 PM in room 22 revealed the fire sprinkler head hanging down approximately 6 inches below the false ceiling. Further observation revealed that the fire sprinkler head was loose. Interview with the facility maintenance staff at the time of observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.3.5.1; 9.7.5 2011 NFPA 25, Section: 5.2.3 .	K 353	3. The sprinkler head in room 22 has been repaired and is no longer hanging loose. 4. A facility-wide audit of sprinkler heads has been conducted to ensure sprinkler heads are free of obstruction of the spray pattern and properly installed. 5. Administrator has educated the staff to the deficiencies noted. 6. Maintenance Director designee will audit 20 random sprinkler heads each week x a minimum of 3 months, to ensure they are not obstructed and are properly installed. Immediate remedy will occur for identified deficiencies. 7.Results of audits will be reviewed at monthly QAPI meetings x 3 months to address findings and determine continuation.	
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	K 511		3/5/20

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K 511	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain electrical systems in accordance with the 2012 NFPA 101, Life Safety Code and the 2011 National Electrical Code. Failure to maintain electrical systems as required could cause a fire resulting in injury or death. The deficiencies affected two (2) of numerous rooms in the facility. The findings were: Observation on 1/28/2020 at 1:04 PM in room S2 revealed equipment stored within three (3) feet of electrical panels. Further observation in the east custodial closet also revealed equipment stored in front of electrical panels. Interview with the facility maintenance staff at the time of observation acknowledged the equipment, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Section: 9.1.2 2011 NFPA 70, Section: 110-26 .	K 511	This plan of correction is prepared and submitted as required by law. By submitting this plan of correction, Shepherd of the Valley Rehabilitation and Wellness Center does not admit that the deficiency listed on this form exists, nor does the center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiency. The center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts and conclusions that form the basis for the deficiency. The facility will ensure the electrical systems are maintained in accordance with the 2012 NFPA 101 Life Safety Code and the 2011 National Electrical Code. This will be accomplished by: 1. The equipment in room S2 has been removed and the electrical panel is no longer obstructed. The equipment in the East custodial closet has been removed so that the electrical panel is no longer obstructed. 2. A facility wide audit of electrical panels has ben conducted to ensure there are no obstructions. 3. Administrator has educated the staff to the above deficiency. 4. Maintenance Director or designee will conduct weekly audits of 10 random spaces x a minimum of 3 months on electrical panels to ensure there is nothing obstructing them. Immediate corrective action will take place for identified deficient practice.	

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K 511	Continued From page 10	K 511	5. Results of audits will be reviewed at monthly QAPI meetings x 3 months to address findings and determine continuation.	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain electrical systems in accordance with the 2012 NFPA 101, Life Safety Code, the 2012 NFPA 99, Health Care Facilities Code, and the 2011 NFPA 70, National Electric	K 920	This plan of correction is prepared and submitted as required by law. By submitting this plan of correction, Shepherd of the Valley Rehabilitation and Wellness Center does not admit that the	3/5/20

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEPHERD OF THE VALLEY REHABILITION AND WELLNESS	**60 MAGNOLIA** **CASPER, WY 82604**

(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 920	Continued From page 11 Code. Failure to maintain electrical systems as required could cause a fire resulting in injury or death. The deficiencies affected four (4) of numerous rooms in the facility. The findings were: 1. Observation on 1/28/2020 at 1:00 PM revealed resident room 18 had patient care related electrical equipment (PCREE) plugged into a power strip located next to the resident's bed. Further observation in room 107 also revealed patient care related electrical equipment (PCREE) plugged into a power strip located under the resident's bed. Resident rooms with patient care related electrical equipment shall not have a power strip. Interview with the facility maintenance staff at the time of observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.5.1.1; 9.1.2 2012 NFPA 99, Sections: 10.2.4; 10.2.3.6 2011 NFPA 70, Section: 400-8 2. Observation on 1/28/2020 at 3:16 PM in the activities room revealed a power strip plugged into a power strip creating a daisy chain. Further observation in the central supply office revealed another daisy chain. Interview with the facility maintenance staff at the time of observation acknowledged the daisy chains, and indicated awareness of the requirement. Interview with the facility administrator at the time	K 920	deficiency listed on this form exists, nor does the center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiency. The center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts and conclusions that form the basis for the deficiency. The facility will maintain electrical systems in accordance with 2012 NFPA 99, the 2012 NFPA 101 Life Safety Code, Health Care Facilities Code, the 2011 NFPA 70 National Electrical Code. This will be accomplished by: 1. The electrical equipment (PCREE) is no longer plugged in to a power strip in rom 18 or 107. The daisy chained power strip in the activity room and central supply office have been removed. 2. A facility wide audit has been completed to ensure that the PCREE equipment is not plugged into power strips and there are no daisy-chained power strips in use. 3.Administrator has educated the staff to the deficient practice. 4. Maintenance Director or designee will conduct a weekly audit of 20 random spaces x a minimum of 3 months to ensure there is compliance the use of power strips and make immediate correction when indicated. 5. The audit results will be reviewed at monthly QAPI meetings x 3 months to address findings and determine continuation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535042	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/29/2020**

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K 920	Continued From page 12 of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.5.1.1; 9.1.2 2011 NFPA 70, Section: 400-8	K 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535042	A. BUILDING _____ B. WING _____	01/29/2020

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E 000	Initial Comments An Emergency Preparedness survey was conducted by Healthcare Licensing and Surveys on January 29, 2020. Based upon the findings of the survey team, it was determined the facility was in compliance with all requirements.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 02/24/2020

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.