STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345133	A. BUILDING _____ B. WING _____	C 04/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURIS AT WILKESBORO TRANSITIONAL CARE & REHAB CNTR	1000 COLLEGE STREET WILKESBORO, NC 28697

(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 A recertification survey was conducted on 04/08/19 through 04/11/19 by the Division of Health Service Regulation, Nursing Home Section. The facility was in compliance with the requirements of CFR 483.73, Emergency Preparedness. Event ID #WFEC11.	E 000		
F 000	INITIAL COMMENTS On 04/11/19 the Division of Health Service Regulation, Nursing Home Section conducted an on-site follow-up survey combined with the annual recertification survey and complaint survey. The facility remains out of compliance. No deficiencies were cited as a result of the complaint investigation.	F 000		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, resident, staff and physician interviews the facility failed to provide physician ordered treatment to care for a	F 686	1. Based on observations, resident, staff and physician interviews the facility failed to provide physician ordered treatment to	4/17/19

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

Electronically Signed | 05/03/2019

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F 686	Continued From page 1 resident's pressure ulcer for 1 of 3 sampled residents (Resident #335). The findings included: Resident #335 was admitted to the facility on 03/18/19 with diagnoses that included type 2 diabetes and others. The most recent Minimum Data Set (MDS) dated 03/25/19 specified the resident's cognition was intact, she did not refuse care and she had 1 unhealed unstageable pressure ulcer present on admission. The care plan dated 03/18/19 to address the resident's pressure ulcer specified interventions for the treatment of the pressure ulcer included: - Administer treatments as ordered A physician's order dated 03/28/19 specified the pressure ulcer on the resident's right heel was to be cleaned daily with wound cleaner, collagen sheet applied and followed with calcium alginate. Review of the Treatment Administration Record (TAR) for March 2019 and April 2019 revealed dates where the nurse failed to document that the treatment had been completed. The dates were: - 03/31/19 - 04/06/19 was initialed by Nurse #1 as having been completed - 04/07/19 Review of the facility's daily staffing assignments revealed the following nurses were assigned to Resident #335: - 03/31/19 Nurse #3	F 686	care for a resident's pressure ulcer for 1 of 3 sampled residents (Resident #335). Resident□s treatment was changed and documented on 4/8/19. 2. All residents with pressure areas with treatment orders were audited on 4/8/19 for treatment completion. No other residents were affected. 3. Licensed nurses were in-serviced on 4/13/19 on professional expectation that pressure wound treatments will be completed as ordered by physician. Pressure wound dressings will be monitored 6 times a week by Director of Nursing Services/ Wound Nurse/ Unit Managers to assure compliance. 4. Audits will be taken to QAPI meeting x 3 months by the Director of Nursing for discussion and review by the interdisciplinary team which consist of the Administrator, Director of Nursing, all department heads and the Medical Director, to assure continued compliance is maintained. Any concerns identified in the QAPI meeting will be discussed and an appropriate plan and interventions will be put into place. Upon completion of the initial 3 month process the QAPI team will discuss and determine if there is a need for continued monitoring. The Director of Nursing or nurse supervisor will audit systemic changes and be responsible for presenting information to the QAPI team. Director of Nursing will be responsible for the ongoing compliance of F 686. The alleged compliance date is 4/17/19.	

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F 686	Continued From page 2 - 04/06/19 Nurse #1 - 04/07/19 Nurse #2 On 04/08/19 at 10:46 AM Resident #335 was interviewed in her room and observations were made of the Resident's dressing intact to her right foot. The dressing was dated 04/05 (no year) and initialed by Treatment Nurse. During the interview the resident was asked about the dressing to her right foot and she stated that the dressing had not been changed since 04/05/19 and usually not changed on the weekend because the Treatment Nurse did not work the weekends. On 04/09/19 at 11:40 AM Nurse #1 was interviewed and explained that on the weekends nurses were expected to also do treatments. She stated that she worked on 04/06/19 and "clicked" the TAR for Resident #335 but never got a chance to do the treatment. On 04/10/19 at 2:57 PM Resident #335 gave permission for wound care to be observed on her right foot. The wound care was performed by the Treatment Nurse (TN) and after removing the dressing, the resident asked how the wound looked. The TN reported, "it looked about the same." On 04/11/19 at 10:12 AM the Wound Physician (WP) was interviewed prior to starting rounds and reported that he was in the facility weekly and followed wounds until they healed. He added that he expected nurses to perform treatments as ordered. Nurse #2 was an agency nurse used by the facility on occasion. Numerous attempts were	F 686		

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F 686	Continued From page 3	F 686		

made to contact the nurse for an interview, but she was unable to be reached.

On 04/11/19 at 1:32 PM the Physician's Assistant (PA) was interviewed and reported he expected treatment orders to be followed as written and documented correctly.

On 04/11/19 at 2:17 PM the Treatment Nurse (TN) was interviewed and explained she worked Monday through Friday and completed all treatments. She stated that on occasion, she had observed treatments not having been completed when she started treatments of Monday. She added that any concerns were reported to the Director of Nursing (DON).

On 04/11/19 at 2:32 PM the Director of Nursing (DON) was interviewed and stated she expected nurses to complete dressings as ordered and to correctly document on the TAR.

On 04/11/19 at 3:17 PM Nurse #3 was interviewed and reported that when she worked the weekends she was responsible for completing treatments. She explained that she had to toggle between the Medication Administration Record (MAR) and Treatment Administration Record (TAR) to know what treatments were due on the shift she worked during the weekend. Nurse #3 added that it was possible she had completed a treatment and failed to document. Nurse #3 was asked about working on 03/31/19 and she stated she did not recall working but if she had, she should have completed Resident #335's treatment as ordered and documented on the TAR.

On 04/11/19 at 3:22 PM the Scheduler verified in

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F 686	Continued From page 4 the facility's payroll system that Nurse #3 did work on 03/31/19 and was assigned to Resident #335.	F 686		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to store ice scoops under sanitary conditions in 1 of 1 ice machine and failed to remove opened unlabeled food items and unlabled personal food items in 2 of 2 nourishment rooms. The findings included: a. An initial tour of the kitchen was made on 04/08/19 at 9:44 AM with the Dietary Manager (DM). Observations of the kitchen revealed one	F 812	1. Based on observations and staff interviews the facility failed to store ice scoops under sanitary conditions in 1 of 1 ice machine and failed to remove opened unlabeled food items annullable personal food items in 2 of 2 nourishment rooms. The scoop was removed, cleaned, and sanitized immediately as well as the ice scoop holder. Food items in the refrigerator in the nourishment rooms that were not labeled with dates or names on the items were removed and discarded	4/17/19

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F 812	Continued From page 5 ice machine used to serve residents had a scoop container attached to the side of the machine. Two ice scoops were stored in the container. Observations inside the container revealed water accumulation. Brownish colored debris was observed floating in the water. The tip of one of the ice scoops was noted to be resting in the water with the brownish, floating debris. The DM removed the scoop container and wiped the debris using a paper towel. The DM reported that the scoops had been used for the breakfast meal service that morning. The DM stated that the scoop container likely had water inside because the scoops had just recently been used. The DM was not aware if the scoops and/or container had recently been sanitized. b. Observations were made of the ICF nourishment room on 04/08/19 at 9:54 AM with the Dietary Manager (DM). The DM explained that the nourishment refrigerator was checked daily by dietary staff twice daily and any unlabeled items were expected to be removed from use. The following items were stored in the ICF nourishment room refrigerator: - A tossed salad not dated, and the lettuce was noted to be brown and wilted - Food unable to be identified labeled 4/2 - Two plastic bags of unlabeled pizza - a bag of fast food not labeled - Thickened juice opened but not labeled. During the observations, the DM was interviewed about the thickened liquid containers and reported that once open, the thickened liquids were good for 7 days. On 04/08/19 at 10:01 AM the SNF nourishment	F 812	immediately. 2. Ice scoop was immediately removed from container. Ice scoop and container were cleaned and sanitized. Refrigerators in both nutrition rooms were audited for any other items not labeled and dated. No other items were found. 3. Dietary to clean and sanitize the ice scoops and holding container 7 days a week, which will be added to the cleaning schedule. Audits to be completed 5 days a week for sanitation of the ice scoops and container by the Dietary Manager and cooks. Nutritional pantry refrigerators to be audited 5 days a week for items not labeled. Dietary Manager and/or Unit Managers will conduct audits and discard any undated items. Dietary staff and Unit Managers in-serviced on 4/14/19. 4. Audits will be taken to QAPI meeting x 3 months by the Administrator for discussion and review by the interdisciplinary team which consist of the Administrator, Director of Nursing, all department heads and the Medical Director, to assure continued compliance is maintained. Any concerns identified in the QAPI meeting will be discussed and an appropriate plan and interventions will be put into place. Upon completion of the initial 3 month process the QAPI team will discuss and determine if there is a need for continued monitoring. The Administrator will audit systemic changes and be responsible for presenting information to the QAPI team. Administrator will be responsible for the ongoing compliance of F 686. The alleged compliance date is 4/17/19.	

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F 812	Continued From page 6 room refrigerator was observed with the DM and noted to have opened containers of thickened liquids with no label / date to indicate when the items were opened. The DM was interviewed and reported she expected staff to date the containers when opened because they were good for 7 days after opening.	F 812		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care	F 842		4/17/19

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F 842	Continued From page 7 operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and resident and staff interviews the facility failed to	F 842	1. Based on observations, record reviews and resident and staff interviews the	

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F 842	Continued From page 8 document treatments for wound care for 2 of 3 sampled residents for pressure ulcers (Resident #63 and #335). Findings included: 1. Resident #63 was admitted to the facility on 02/09/18 with diagnoses which included heart failure, high blood pressure, generalized muscle weakness and thyroid disease. A review of the most recent significant change Minimum Data Set (MDS) dated 01/31/19 revealed Resident #63 was moderately impaired in cognition for daily decision making. The MDS also revealed Resident #63 required extensive assistance for activities of daily living except she only required supervision with eating. A review of a care plan created on 02/01/19 revealed in part Resident #63 had a pressure ulcer or the potential for a pressure ulcer related to immobility and incontinence. A goal indicated the pressure ulcer would show signs of healing and remain free from infection and the interventions were listed in part to administer treatments as ordered and monitor, document and report any changes in skin status. A review of a Physician order dated 02/15/19 indicated to cleanse sacral area with normal saline and apply Collagen (a protein to promote healthy skin) and cover with a dry dressing every day shift for wound care. A review of a Treatment Administration Record (TAR) dated 02/28/19 revealed the treatment space was blank to cleanse sacral area with normal saline and apply Collagen and cover with	F 842	facility failed to document treatments for wound care for 2 of 3sampled residents for pressure ulcers (Resident #63 and #335). Both resident□s treatment record audited for accuracy. 2. Residents□ documentation with pressure areas were audited for missing documentation. 3 of residents of 12 of residents had missing documentation. 3. Licensed nurses were in-serviced on 4/13/19 on the professional expectations that when a treatment for pressure areas are completed, per physician□s orders it must be documented in Point Click Care on Treatment Record. Point Click Care Dash Board will be audited as well as treatment records 5 days a week by Director of Nursing Services/ Wound Nurse/ Unit managers to assure pressure wound treatments have been documented. 4. Audits will be taken to QAPI meeting x 3 months by the Director of Nursing for discussion and review by the interdisciplinary team which consist of the Administrator, Director of Nursing, all department heads and the Medical Director, to assure continued compliance is maintained. Any concerns identified in the QAPI meeting will be discussed and an appropriate plan and interventions will be put into place. Upon completion of the initial 3 month process the QAPI team will discuss and determine if there is a need for continued monitoring. The Director of Nursing or nurse supervisor will audit systemic changes and be responsible for presenting information to the QAPI team. Director of Nursing will be responsible for	

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F 842	Continued From page 9	F 842		

a dry dressing every day shift for wound care.

A review of staffing schedules dated 02/28/19 revealed Nurse #4 was assigned to Resident #63.

An interview on 04/11/19 at 11:12 AM with Nurse #4 revealed the facility had a Treatment Nurse who did treatments Monday through Friday but day shift nurses were responsible to do treatments when the Treatment Nurse was not in the facility. She explained 02/28/19 was a Thursday so the Treatment Nurse would have done Resident #63's dressing change that day.

A review of a Physician's order dated 03/08/19 indicated to apply Santyl (for removal of dead tissue) to sacral wound and then Calcium Alginate (absorbent dressing to promote healing) and border dressing every day for wound care.

A review of a TAR dated 03/10/19 revealed the treatment space was blank to apply Santyl to sacral wound and then Calcium Alginate and border dressing every day for wound care.

A review of staffing schedules dated 03/10/19 revealed Nurse #5 was assigned to Resident #63.

A telephone interview on 04/11/19 at 2:00 PM with Nurse #5 revealed she was expected to document treatments for pressure ulcers after she did them. She stated she could not recall why she did not document a pressure ulcer treatment on 03/10/19 for Resident #63 because she was not sure the treatment appeared on her computer screen for her to do the treatment that day.

A review of a TAR dated 03/16/19 revealed the

the ongoing compliance of F 686. The alleged compliance date is 4/17/19.

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F 842	Continued From page 10	F 842		

treatment space was blank to apply Santyl to sacral wound and then Calcium Alginate and border dressing every day for wound care.

A review of staffing schedules dated 03/16/19 revealed Nurse #6 was assigned to Resident #63.

A telephone interview on 04/11/19 at 2:05 PM with Nurse #6 revealed she was unable to work on 03/16/19 and did not know who had taken her place that day. She stated she did not know why Resident #63's treatment was not documented.

A review of a TAR dated 03/23/19 and 03/24/19 revealed treatment spaces were blank to apply Santyl to sacral wound and then Calcium Alginate and border dressing every day for wound care.

A review of staffing schedules dated 03/23/19 and 03/24/19 revealed Nurse #4 was assigned to Resident #63.

An interview on 04/11/19 at 11:12 AM with Nurse #4 revealed she was responsible to do treatments when the Treatment Nurse was not in the facility. She further explained she had to remember to click out of the Medication Administration Record and go into the TAR to document treatments and sometimes it was easy to forget to document them.

A review of a TAR dated 03/25/19 revealed the treatment space was blank to apply Santyl to sacral wound and then Calcium Alginate and border dressing every day for wound care.

A review of staffing schedules dated 03/25/19 revealed Nurse #7 was assigned to Resident #63.

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F 842	Continued From page 11	F 842		

An attempt to contact Nurse #7 on 04/11/19 at 2:03 PM was unsuccessful.

A review of a TAR dated 03/26/19 revealed the treatment space was blank to apply Santyl to sacral wound and then Calcium Alginate and border dressing every day for wound care.

A review of staffing schedules dated 03/26/19 revealed Nurse #4 was assigned to Resident #63.

An interview on 04/11/19 at 11:12 AM with Nurse #4 revealed 03/26/19 was a Tuesday and the Treatment Nurse would have done Resident #63's dressing change that day.

A review of a Physician's order dated 03/28/19 indicated to place Aquacell to sacral wound and cover with border gauze every day for wound care.

A review of a TAR dated 04/07/19 revealed the treatment space was blank to place Aquacell to sacral wound and cover with border gauze every day for wound care.

A review of staffing schedules for 04/07/19 revealed Nurse #2 was assigned to Resident #63.

An attempt on 04/11/19 at 10:37 AM to contact Nurse #2 was unsuccessful.

An observation on 04/10/19 at 11:54 AM of wound care for Resident #63 by the Treatment Nurse revealed Resident #63 had a small open area on her sacrum that was clean and without drainage. The Treatment Nurse cleaned the wound with wound cleanser and applied Aquacell to the sacral wound and covered it with a border

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345133	A. BUILDING _____ B. WING _____	C 04/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURIS AT WILKESBORO TRANSITIONAL CARE & REHAB CNTR	1000 COLLEGE STREET WILKESBORO, NC 28697

(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
F 842	Continued From page 12	F 842		

gauze.

An interview on 04/11/19 at 2:22 PM with the Treatment Nurse revealed she worked Monday through Friday and did all of the wound treatments for residents. She explained Nurses were expected to do treatments and document them on the resident's TAR when she was not there. She further explained when she did treatments she did not have a computer to take with her so she occasionally missed documentation of the treatments. She further stated she was certain she had done pressure ulcer treatments for Resident #63 and her pressure ulcer was healing but she had probably forgotten to document the treatments since the spaces on the TARs were blank.

An interview on 04/11/19 at 2:43 PM with the Director of Nursing revealed it was her expectation for treatments to be done and Nurses should document them. She stated after review of Resident #63's TARs she felt the treatments were done but there was a documentation issue and education needed to be done.

2. Resident #335 was admitted to the facility on 03/18/19 with diagnoses that included type 2 diabetes and others.

A physician's order dated 03/28/19 specified the pressure ulcer on the resident's right heel was to be cleaned daily with wound cleaner, apply collagen sheet and follow with calcium alginate.

Review of the Treatment Administration Record (TAR) revealed documentation that wound care to the right heel was provided on 04/06/19 by Nurse #1.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345133	A. BUILDING _____ B. WING _____	C 04/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURIS AT WILKESBORO TRANSITIONAL CARE & REHAB CNTR	**1000 COLLEGE STREET WILKESBORO, NC 28697**

(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
F 842	Continued From page 13 On 04/08/19 at 10:46 AM Resident #335 was interviewed in her room and during the interview observations were made of the Resident's dressing intact to her right foot. The dressing was dated 04/05 (no year) and initialed by Treatment Nurse. During the interview the resident was asked about the dressing to her right foot and she stated that the dressing had not been changed since 04/05/19 because the Treatment Nurse did not work the weekends. On 04/09/19 at 11:40 AM Nurse #1 was interviewed and explained that on the weekends nurses were expected to also do treatments. She stated that she worked on 04/06/19 and "clicked" the TAR for Resident #335 but never got a chance to do the treatment. Nurse #1 added that she reported off to the oncoming shift that the treatment had not been completed. On 04/11/19 at 2:32 PM the Director of Nursing (DON) was interviewed and stated she expected nurses to complete dressings as ordered and to correctly document on the TAR.	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345133	A. BUILDING _____ B. WING _____	R-C 04/11/2019

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F 000	INITIAL COMMENTS On 04/11/19 the Division of Health Service Regulation, Nursing Home Section conducted an on-site follow-up survey combined with the annual recertification survey and complaint survey. The deficiencies cited on 02/01/19 were corrected as of 04/11/19. However, the facility remains out of compliance as result of the recertification survey.	F 000		

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

Electronically Signed

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.