

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

PRINTED: 08/26/2010  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186294	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  08/20/2010
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NAME OF PROVIDER OR SUPPLIER  MAPLE MANOR HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 515 GREENE DRIVE GREENVILLE, KY 42345
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F 000	INITIAL COMMENTS  An annual survey was conducted 08/18/10 through 08/20/10 to determine the facility's compliance with Federal Regulatory Requirements. Deficiencies were identified with the highest S/S being a "D".	F 000	<i>This Plan of Correction is the center's credible allegation of compliance.</i>	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, it was determined the facility failed to meet professional standards of quality for one resident (#13) in the selected sample of 19, related to following the five rights of medication administration. Findings include:  An observation, on 08/18/10 at 11:00 AM, revealed Intravenous (IV) medications hanging from an IV pole and infusing into Resident #13's Peripherally Inserted Central Catheter (PICC) via IV pump. Upon further observation, it was noted the Piggyback Bag was not labeled properly. The bag contained 0.9% Normal Saline (NS). Written on the back of the bag, in black marker, was the name of the drug and the milligrams (mg) of the drug. A date was also noted on the bag. There was no label on the bag identifying the resident's name, the name of the drug, the amount of the drug, the route of the drug, and the time the drug was added. Furthermore, there was not an infusion rate on the bag or the initials of the person who added the medication into the bag.	F 281	<b>F281 SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</b> It is the practice of Maple Manor to provide services that meet professional standards of quality.  Resident #13's IV bag was properly labeled and the nurse was reeducated 8/18/10. A review of the census and conditions report revealed no other residents in the facility currently have IV's. The Staff Development Nurse will be responsible to see that all facility nurses complete an IV skill validation competency by 9/10/10. The Staff Development Nurse will be responsible to see that an audit is completed each week for the next 3 months, of nurse's providing IV services; IV's skills will be validated at least annually from thereafter. The facility quality assurance team will review the results of the audits each month for 3 months, in the monthly PI meeting, to determine if compliance is satisfactory.	9/10/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Alicia Hensley</i>	TITLE <i>Administrator</i>	(X6) DATE <i>9/13/10</i>
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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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F 281	<p>Continued From page 1</p> <p>A review of the physician's orders dated 08/13/10, revealed "Protonix 40 mg IV every 12 hours times 10 days" to be infused for Gastroesophageal Reflux. A review of the physician's orders dated 08/18/10, revealed "Infuse Protonix IV at 200 milliliters (ml) per hour over 30 minutes in 100 ml of NS, bag constituted with 10 ml of NS".</p> <p>An interview with the Utilization Coordinator, on 08/18/10 at 11:05 AM, revealed "This was the first time that I used the IV pump. I have been in-serviced, but I do not work this floor and I knew that I had done something wrong. That's why I got someone. I knew to turn the pump off, but I didn't".</p> <p>An observation, on 08/18/10 at 11:07 AM, revealed the Utilization Coordinator initialing a label in the hallway at the nurse's station. Upon further observation, on 08/18/10 at 11:10 AM, there was a label in place on the back of Resident #13's IV bag with the proper labeling on the bag, that was not present during the observation ten minutes earlier, at 11:00 AM.</p> <p>An interview with the Director of Nursing (DON), on 08/20/10 at 10:20 AM, revealed Protonix was a medication mixed in the facility. The DON further stated, "The Protonix decreases in concentration if it is not infused within six hours of mixing. So, we mix it here".</p> <p>A review of the facility's policy and procedure, "Administration of IV Fluids and Medications", dated 04/08, revealed consultation with an IV pharmacist as needed. The policy also stated the IV bag was to be labeled with the "resident's name, medication added, dose, date, time, and initials".</p>	F 281		

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<p>F 315 SS=D</p>	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined the facility failed to ensure appropriate catheter/incontinent care was provided for one resident (#2), in the selected sample of 19. Findings include:  A record review revealed Resident #2 was admitted to the facility on 03/02/09 with diagnoses to include Urinary Tract Infection, Hypotension, Cardiac Dysrhythmia, and Chronic Kidney Disorder.  Review of the quarterly Minimum Data Set (MDS), dated 06/28/10, revealed the resident was mildly cognitively impaired and required total assistance with all of his/her activities of daily living (ADL). Additionally, the resident was incontinent of bowel and had an indwelling catheter. due to a pressure area on his/her coccyx.  An observation, on 08/18/10 at 4:10 PM, revealed Certified Nurse Aide (CNA) #2 provided</p>	<p>F 315</p>	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p><b>F315 NO CATHETER/PREVENT UTI/RESTORE BLADDER</b></p> <p>It is the practice of Maple Manor to ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization is necessary; and residents who are incontinent of bladder receive appropriate treatment and services to prevent urinary tract infections and to restore as much bladder function as possible.</p> <p>Resident #2 was provided proper foley cath care and monitored for any possible signs or symptoms of infection; C.N.A.#2 was reeducated about foley catheter care on 8/18/10. A review of the census and conditions report revealed other residents with foley catheters. The Staff Development Nurse will be responsible to see that all the other facility residents with foley catheters are being provided proper catheter care, by 9/10/10. The Staff Development Nurse will see that a validation of all facility C.N.A.'s skill competencies with foley catheter care be done by 9/10/10. The Staff Development Nurse, will see that a weekly audit is completed on foley catheter care for the next 3 months and report the results to the QA team monthly; foley catheter care technique competencies will be completed at least annually from thereafter. For the next 3 months, the facility quality assurance team will review the results of the validations competencies in the monthly PI meetings to determine if compliance is satisfactory.</p>	<p>9/10/10</p>
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F 315	<p>Continued From page 3</p> <p>inappropriate catheter/incontinent care for Resident #2. CNA #2 did not wash her hands prior to putting on her gloves. She cleaned the catheter tubing with soap and water; however, she cleaned back and forth on the catheter tubing. Afterward, when drying the resident's catheter tubing off with a clean towel, she went from the catheter tubing back to the resident's skin. She laid the soiled washcloths/towel on the resident's bedside table. Once she provided the catheter care, she went to the resident's closet without changing her gloves or washing her hands and proceeded to provide (bowel) incontinent care for the resident. After all of the care was provided, she touched various items belonging to the resident with her dirty gloves. No handwashing was completed at that time. She left the resident's room without removing the dirty gloves before exiting and carried a plastic bag, which contained the soiled washcloths/towel. She went to the soiled utility room where she removed her gloves and washed her hands.</p> <p>An interview with CNA #2, on 08/18/10 at 4:45 PM, revealed the resident received catheter/incontinent care every two hours and as needed (PRN). She had been a CNA for 16 years and had been trained on catheter/incontinent care. She stated she did not know why she did not wash her hands prior to the care, why she did not put soiled washcloths/towel in a plastic bag instead of on the bedside table, or why she touched various items without removing the dirty gloves first. Additionally, she stated she had provided incontinent care this way in the past. She could provide no further explanation as to why inappropriate care was provided for this resident.</p>	F 315			

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F 315	Continued From page 4 A review of the facility's policy/procedure, "Indwelling Urinary Catheter Care," dated 04/28/10 and a review of the facility's policy/procedure, "Incontinence/Perineal Care," dated 10/31/09, revealed "Perform hand hygiene and put on gloves. Wash perineum beginning at the junction of the catheter tubing and meatus working outward to the surrounding perineal structures with soap and warm water or a no rinse cleansing solution and cleaning from front to back. Cleanse area well and remove all debris from catheter at insertion site. Do pull on catheter or advance it further into urethra. Rinse well with warm water and pat dry gently with a clean towel. Remove gloves, perform hand hygiene."	F 315	<i>This Plan of Correction is the center's credible allegation of compliance.</i>  <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.	F 441	<b>F441 INFECTION CONTROL 9/10/10 PREVENT SPREAD/LINENS</b> It is the practice of Maple Manor to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  RN#1 was reeducated about dressing change and hand washing technique and procedures on 8/18/10. A review of the census and conditions report revealed other residents with dressing changes. The Staff Development Nurse will see that other residents with dressing changes are being provided proper care by 9/10/10; also, she will see that all licensed staff are educated on proper dressing change technique and hand washing by 9/10/10. The Staff Development Nurse will see that a weekly audit is completed of nurse dressing changes skills for the next 3 months; dressing change competencies will be completed at least annually from there after. The facility quality assurance team will review the results of the validation competencies for the next 3 months, in the monthly PI meeting to determine if compliance is satisfactory.		

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F 441	<p>Continued From page 5</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews, it was determined the facility failed to maintain aseptic technique during wound care for one resident (#2), in the selected sample of 19. Findings include:</p> <p>A record review revealed Resident #2 was admitted to the facility on 03/02/09 with diagnoses to include Urinary Tract Infection, Hypotension, Cardiac Dysrhythmia, and Chronic Kidney Disorder.</p> <p>Review of the quarterly Minimum Data Set (MDS), dated 06/28/10, revealed the resident was mildly cognitively impaired and required total assistance with all of his/her activities of daily living (ADL). Additionally, the resident had a stage II pressure sore on his/her coccyx area.</p> <p>A review of physician's orders, dated 03/04/10, revealed "Wet to dry dressing twice daily to</p>	F 441			

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F 441	Continued From page 6 coccyx, no tape."  An observation, on 08/18/10 at 3:30 PM, revealed Registered Nurse (RN) #1 washed her hands and put on her gloves prior to the resident's dressing change on his/her coccyx area; however, RN #1 plcked up an abdominal (ABD) pad off the floor with her gloved hand and laid the ABD pad on the bedside table. She then proceeded to check the resident's wound to remove the packing by sticking her gloved finger in the resident's wound. She removed her gloves and washed her hands. She put on more gloves to apply the new dressing and proceeded to pack the wound with saline soaked guaze using her gloved finger.  An interview with RN #1, on 08/18/10 at 4:55 PM, revealed picking up the item off the floor was wrong, but she could provide no explanation as to why she did this. Additionally, she stated she should not have stuck her gloved finger in the resident's wound. She revealed she usually used a Q-tip when she packed the resident's wound, but she did not do that this time.  An interview with the Director of Nursing (DON), on 08/20/10 at 2:00 PM, revealed she expected the nurses to follow the facility's policy and procedure for all dressing changes.  A review of the facility's policy/procedure, "Infection Control and Prevention Program," dated 10/31/09, revealed " The center's infection control program includes implementing policies and procedures to prevent the spread of infections that include promoting consistent adherence to standard precautions and other infection control practices."	F 441			
F 444	483.65(b)(3) PREVENTING SPREAD OF	F 444			

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F 444 SS=D	Continued From page 7  INFECTION  The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice.  This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, it was determined the facility failed to ensure staff members washed their hands or changed gloves after direct contact with each resident. Observations on 08/18/10 through 08/20/10 revealed staff were not washing their hands and/or changing their gloves after contact with two residents (#2 and #5), in the selected sample of 19. Findings include:  1. A record review revealed Resident #2 was admitted to the facility on 03/02/09 with diagnoses to include Urinary Tract Infection, Hypotension, Cardiac Dysrhythmia, and Chronic Kidney Disorder.  Review of the quarterly Minimum Data Set (MDS), dated 06/28/10, revealed the resident was mildly cognitively impaired and required total assistance with all of his/her activities of daily living (ADL).  An observation, on 08/18/10 at 4:10 PM, revealed Certified Nurse Aide (CNA) #2 did not wash her hands prior to putting on her gloves to provide catheter/incontinent care for Resident #2. Once she provided the catheter care, she went to the resident's closet without changing her gloves or	F 444	<i>This Plan of Correction is the center's credible allegation of compliance.</i>  <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>  <b>F444 PREVENTING SPREAD OF INFECTION</b> It is the practice of Maple Manor to require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.  Resident #2 was provided proper foley cath care and monitored for any possible signs or symptoms of infection; resident #2's wound was monitored for any possible signs or symptoms of infection; resident #5 was monitored for any possible signs of symptoms of infection. C.N.A. #1, C.N.A.#2, and RN#2 were reeducated about preventing the spread of infection and hand washing technique on 8/18,19/10. The Staff Development Nurse will see that all nursing department staff are reeducated about proper hand washing technique by 9/10/10. The Staff Development Nurse will see that an audit of nurses and nurse aides hand washing is completed weekly over the next 3 months; hand washing competencies will be completed at least annually from there after. For the next 3 months, the facility quality assurance team will review the results of the weekly audits in the monthly PI meeting to determine if compliance is satisfactory.	9/10/10	

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F 444	<p>Continued From page 8</p> <p>washing her hands, came back to the resident's bedside and proceeded to provide (bowel) incontinent care for the resident with the same dirty gloves. After all of the care was completed, she touched various items belonging to the resident with the dirty gloves. No handwashing was completed at that time. She walked out of the resident's room with the dirty gloves still on her hands, and carried a plastic bag, which contained the soiled washcloths/towel to the soiled utility room. She removed her gloves and washed her hands at that time.</p> <p>An interview with CNA #2, on 08/18/10 at 4:45 PM revealed, she had been a CNA for 16 years and had been trained on proper handwashing/gloving techniques. She stated she did not know why she did not wash her hands prior to providing the care, why she touched the items and then provided more care with her dirty gloves still in place, or why she left the resident's room without removing her gloves and washing her hands. Additionally, she stated she had provided incontinent care this way in the past. No further explanation was provided.</p> <p>Additionally, an observation, on 08/20/10 at 9:10 AM, revealed Registered Nurse (RN) #2 did not wash her hands prior to putting on gloves to complete a dressing change for Resident #2's lower extremities.</p> <p>An interview with RN #2, on 08/20/10 at 2:30 PM, revealed she washed her hands at the nurses' station and then went to the treatment cart to gather supplies for the dressing change. After gathering supplies, she went in the resident's room and put on her gloves.</p>	F 444			

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F 444	<p>Continued From page 9</p> <p>A review of the facility's policy/procedure, "Hand Hygiene/Handwashing," dated 10/31/09, revealed "Hand hygiene is to be performed before starting work; after assisting others with toileting or after personal grooming; before taking part in a medical or surgical procedure; after touching blood, body fluids, secretions, excretions, and contaminated items, whether or not gloves are worn; between tasks and procedures on the same resident when contaminated with body fluids to prevent cross contamination of different body sites; if moving from a contaminated body site to a clean body site during resident care; after removal of medical/surgical gloves; after touching bare parts of the body other than clean hands and clean, exposed portions of arms and after contact with a resident's intact skin. Gloves or the use of baby wipes are not a substitute for hand hygiene."</p> <p>2. Record review revealed Resident #5 was admitted to the facility, on 07/09/10, with diagnoses which included a history of a Cerebral Vascular Accident (CVA/Stroke). A review of the Resident Assessment Protocol (RAP) summary, dated 07/14/10, revealed the facility identified Resident #5 as incontinent of bowel and bladder. A review of the current care plan for incontinence, dated 07/14/10, revealed interventions included incontinent care every two hours and PRN (as needed).</p> <p>An observation, on 08/19/10 at 2:10 PM, revealed CNA #1 provided incontinent and peri-care for Resident #5. Resident #5 was observed incontinent of bowel and urine. CNA #1 did not wash her hands prior to donning of gloves, in preparation for the incontinent care. After</p>	F 444			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185294	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  08/20/2010
NAME OF PROVIDER OR SUPPLIER  MAPLE MANOR HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 515 GREENE DRIVE GREENVILLE, KY 42345		
(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 444	<p>Continued From page 10</p> <p>provision of the incontinent and peri-care, the CNA did not remove the contaminated gloves and wash her hands. Additional observation revealed CNA#1 touched the resident's Broda chair, the privacy curtains, a box of clean peri-wipes and the closet door with the contaminated gloves.</p> <p>An interview with CNA #1, on 08/19/10 at 2:30 PM, revealed she was aware she did not wash her hands prior to the donning of her gloves, and unaware she had touched all the objects with the contaminated gloves, until the observation information was shared with her. She stated she did not know why she did not wash her hands, remove her gloves and wash her hands after the care was provided.</p> <p>An interview with the Director of Nursing, on 08/19/10 at 3:00 PM, revealed she always told staff, "You can't wash your hands enough". She stated the staff should wash their hands anytime they enter a room to provide care, during care, if needed, and after completion of care. Sanitizers were located between the resident rooms and should be used between residents, when no direct care was provided.</p>	F 444		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185294</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/23/2010</b>
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NAME OF PROVIDER OR SUPPLIER  <b>MAPLE MANOR HEALTH CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>515 GREENE DRIVE GREENVILLE, KY 42345</b>
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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	<p><b>INITIAL COMMENTS</b></p> <p>A Life Safety Code survey was initiated and conducted on 08/23/10 to determine the facility's compliance with Title 42, Code of Federal Regulations, 483.70 (Life Safety from Fire) and found the facility to be in compliance with NFPA 101 Life Safety Code 2000 Edition. No deficiencies were identified during this survey.</p>	K 000		
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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.