

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435009	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/24/2016
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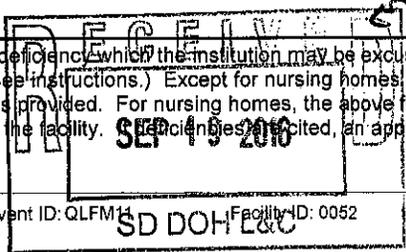
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MILBANK	STREET ADDRESS, CITY, STATE, ZIP CODE 1103 SOUTH SECOND STREET MILBANK, SD 57252
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F 000	INITIAL COMMENTS Surveyor: 33265 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 8/22/16 through 8/24/16. Golden LivingCenter - Milbank was found not in compliance with the following requirements: F248, F281, and F441.	F 000	* Addendums noted with an asterisk per 10/06/16 per telephone with facility DON. NR/SDDOH/EL	
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Surveyor: 36413 Based on observation, record review, interview, and policy review, the provider failed to ensure an ongoing program of activities was provided for: *Two of three sampled residents (3 and 13) who did not actively participate in group activities. *One of one resident council group who expressed an interest in evening programs. Findings include: Surveyor: 26180 1a. Random observations of resident 13 from 8/22/16 at 4:00 p.m. through 8/24/16 at 2:00 p.m. revealed: *He was dependent on staff for all his mobility around the facility.	F 248 #1	*by activity coordinator: Resident #13 and #3 will be re-assessed for activity preferences and care plans revised to address any activity not previously addressed. Residents will be interviewed on discussion will be held at resident council to [redacted] ideas for evening and out of facility activities. *by activity coordinator. Any resident could be affected if activity preferences not met thru scheduled activity calendar and care plans. *next #3 All staff will be inserviceed on 9/22 + 9/23 on activity policy; Calendar of events with addition of evening and out of facility opportunities. Education will be provided on how everyone can contribute to participation in the attendance at programs.	
		#2	*identify NR/SDDOH/EL	
		#4	Activity Director will continue to record activity participation logs and these will be audited by Social Services or designee 2x wkly X 4 then wkly X 4	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Rich Iraman</i>	TITLE	(X6) DATE 9/16/16
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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 excused, an approved plan of correction is requisite to continued program participation.



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F 248	<p>Continued From page 1</p> <p>*On 8/22/16 he was in bed, getting up to eat meals only.</p> <p>*On 8/23/16 he spent a good portion of the day in bed.</p> <p>-At 4:00 p.m. on 8/23/16 he was brought to the front lounge and sat approximately four feet in front of the large screen TV.</p> <p>-His head hung down, and he was not looking at the TV.</p> <p>-He would raise his head if he was spoken to.</p> <p>-He sat in front of the TV until he was brought to the dining room for supper at 5:30 p.m.</p> <p>*On 8/24/16 at 7:50 a.m. he was brought to the area outside the nurses station in front of the bird aviary.</p> <p>-He sat there until 8:15 a.m. when they brought him to the dining room for breakfast.</p> <p>-Following breakfast he was brought to the front lobby and placed in front of the TV at 9:10 a.m.</p> <p>-He sat there until 11:10 a.m. when he was brought to his room to be toileted before to lunch.</p> <p>*Following lunch he was brought to the front lobby and placed in front of the TV at 12:45 p.m.</p> <p>*On the table in his room he had a lot of reading material including devotion books.</p> <p>-He was not seen participating in any independent activities in his room.</p> <p>Review of resident 13's following Minimum Data Set (MDS) assessments revealed his activity preferences were:</p> <p>*5/18/16: News, music, animals, people, getting outdoors and religious programs were all very important to him.</p> <p>*8/11/16: News, music, animals, people, and religious programs were all very important to him.</p> <p>-Getting outdoors was somewhat important to him.</p>	F 248	<p><i>cont.</i></p> <p>for participation in evening and out of facility activities.</p> <p>#5 Results of audits will be reported to QAPI monthly until resolved, with negative finding used to implement new activities</p> <p>→ *by activity Coordinator NR/SDDO/H/EL</p>	10/13/16	

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F 248	<p>Continued From page 2</p> <p>Review of resident 13's 8/18/16 care plan revealed:</p> <ul style="list-style-type: none"> *He preferred morning activities. *Staff were to: <ul style="list-style-type: none"> -Offer him activities and supplies for things he could do in his room such as read magazines or the local newspaper. -Assist him in participating in his favorite activities (but did not specify what those activities were). -Invite and remind him of activities through verbal reminders and the activity calendar. *The goal was to "Continue participating in independent activities and facility activities including reading the newspaper, visiting with family, and group activities such as church, bible study, music and ball toss." *There were no planned interventions for him to get outside. <p>Review of resident 13's 2016 activity participation records revealed his activities included:</p> <p>*June:</p> <ul style="list-style-type: none"> -Watched TV twenty-five out of thirty days. -Had been outside once. -He attended ball toss eight times. -He never attended the weekly county news activity. -He never attended any of the religious programs offered. -There were twenty days he had attended no activity other than watching TV. <p>*July:</p> <ul style="list-style-type: none"> -He watched TV every day except one. -He attended bible study four times, and ball toss six times.. -There were twenty days he attended no activity other than watching TV. <p>*August:</p> <ul style="list-style-type: none"> -He had attended ball toss five times, and bible 	F 248		

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F 248	<p>Continued From page 3</p> <p>study twice.</p> <ul style="list-style-type: none"> -He attended two religious programs. -He watched TV nineteen out of twenty-four days. -He had no documentation of getting outside. <p>*There was no documentation when he was invited to an activity but had refused.</p> <p>Interview on 8/24/16 at 2:45 p.m. with the activity director (AD) regarding resident 13 revealed:</p> <ul style="list-style-type: none"> *His ability to attend activities varied with how he was feeling and if he was having pain. *He did not come to a lot of activities because of his schedule or how he was feeling. *He really liked ball toss and came to that when he could. *He never came to country news, even though he liked the news. *She preferred to have him sit in front of the TV instead of being in his room alone, as it was dark in there. -She was unsure if he actually paid attention to the TV. -She thought he fell asleep a lot. *She did not have time to do individual programming with residents. -She did all the transporting of residents to and from activities and that took a lot of time. -She assisted at meals with meal passing. -Her assistant worked on the days she was off, and so she did not have time to do the individual activities. *He had a nephew who occasionally came to visit him and he would take him outside. -She did not know how often he came, because she was not always there. -She had encouraged his nephew to read to him, because he liked to read but could not do that. He had a lot of reading material. She did not know if his nephew did that. 	F 248		

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F 248	<p>Continued From page 4</p> <p>*She agreed he could have benefited from one-on-one activity, but there was not enough activity staffing hours to do that.</p> <p>Surveyor: 36413</p> <p>1b. Review of resident 3's 7/7/16 Minimal Data Set (MDS) assessment with interests rated very important to her included:</p> <ul style="list-style-type: none"> *Keeping up with the news. *Doing things with groups of people. *Going outside. *Participating in religious practices. <p>Random observations from 8/22/16 at 4:00 p.m. through 8/24/16 at 2:00 p.m. revealed resident 3 had remained in her bed.</p> <p>Review of resident 3's 2016 activity participation records revealed she participated in the following activities:</p> <p>*June:</p> <ul style="list-style-type: none"> -Watched TV twenty-eight days out of thirty. -Communication was marked nine days out of thirty. -There were two days without any activities. -No other activities were recorded on the calendar. <p>*July:</p> <ul style="list-style-type: none"> -She watched TV thirty out of thirty-one days. -Communication was marked six out of thirty-one days. -One day was without any activities. <p>*August:</p> <ul style="list-style-type: none"> -She watched TV eleven out of twenty-one days. -Communication was marked fifteen out of twenty-one days. -No other activities had been marked on calendar. 	F 248			

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F 248	<p>Continued From page 5</p> <p>2. Interview on 8/24/16 at 1:00 p.m. with resident group council revealed: *No activities were scheduled after 5:00 p.m. any day of the week. *No activities were scheduled out of the facility due to not having a bus available for transportation. *Activities in the evening and being able to leave the facility were important to them.</p> <p>Interview on 8/24/16 at 2:30 p.m. with the activity director revealed: *She agreed no activities were done after 5:00 p.m. *Due to shortage of staff activities were done only by activity staff, with one person scheduled from 8:00 a.m. to 4:00 p.m. or 5:00 p.m. daily. *If activities had been planned after 5:00 p.m., there would have been no staff to do them. *They did not have a bus for activities, so all activities were done in-house.</p> <p>3. Review of the provider's 2/24/15 individual programming policy revealed: *"Individual programming ensures that all residents who are unable to or choose not to participate in group programs have consistent, goal-oriented and individualized recreation opportunities. *Residents who are unable or prefer not to participate in group activities will be identified through the assessment process. *Structured individual interventions will be developed based on each resident's history and assessed needs and preferences. *The individual program will be schedule based on resident preference as to day, time of day and duration. *Each resident's individual program will include</p>	F 248		

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F 248	Continued From page 6 interventions which meet the resident's assessed social, emotional, physical, and cognitive functioning needs." 4. Review of the activity coordinator's job description revealed the duties included: *"Interview and assess all residents prior to the initial care plan conference. *Document this information in the medical record, develop an individual recreation plan based on the assessment and participate in Interdisciplinary Care plan meetings. *Update assessments and plans as needed. *Develop monthly recreation program calendars that reflect and meet the needs of facility residents."	F 248		
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: Surveyor: 32331 Surveyor: 37545 Based on record review, interview, and policy review, the provider failed to appropriately document and follow professional standards, nursing scope of practice, and their policy ensuring nursing staff were notifying the physician for pronouncement of death for one of two sampled residents (14) who had died. Findings include: 1. Review of the medical record documentation	F 281	#1 No corrective action in this situation for this resident. *14 is possible. NK/SPDCH/EL #2 Any resident at end of life could potentially have documentation that does not follow policy for end of life #3 Licensed Nurses will be educated at meetings on 9/21 + 9/22 on the Post Mortem Care Policy. [redacted] will also review 5 discharge/death notes for opportunities for improvement. *by DON. #4 DON or Designee will audit the Post Mortem progress notes for policy adherence, any note out of compliance will be reviewed and corrected per [redacted] NK/SPDCH/EL	

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F 281	<p>Continued From page 7 for resident 14 revealed: *He was admitted on 8/7/14. *The 4/24/16 nurse's note by licensed practical nurse (LPN) A had documented "Resident expired at 1326 [1:26 p.m.]."</p> <p>Interview on 8/24/16 at 10:20 a.m. with the director of nursing regarding resident 14's death documentation by LPN A revealed: *She "Should not have documented death." *She needed to have documented the above differently. *She should have followed the provider's policy and procedure for this. *Pronouncement of death was to have been made by a physician.</p> <p>Review of the provider's 5/3/16 Post-Mortem Care policy revealed documentation should have included "Date, time vital signs ceased."</p> <p>Review of Patricia A. Potter et al., Fundamentals of Nursing, 8th Ed., St Louis, MO, 2013, page 724, revealed documentation of end of life included the name of the health care provider who certified death.</p> <p>Review of South Dakota Codified Law 34-25-18 and 34-25-18.1 revealed: *The signing of the death certificate is a medical act by a physician, physician's assistant, or nurse practitioner. *"Since the Legislature did not provide that the act was able to be delegated to anyone else the South Dakota Board of Nursing did not believe a licensed nurse could officially pronounce death."</p> <p>Review of a letter dated 8/4/14 from the South Dakota Board of Nursing revealed:</p>	F 281	<p>(#4 cont) *The most recent NR/SDDO/H/EL late entry. Past 5 discharge death notes will be audited for compliance with policy. *by the DON or designee. NR/SDDO/H/EL</p> <p>#5 Audits for [redacted] will be completed as they occur. Audit findings will be reported to QAPI monthly until resolved. Any areas needing further correction will be action planned. *by the DON</p> <p>*The next five Post Mortem progress notes) NR/SDDO/H/EL</p> <p>→ *by the DON or designee. NR/SDDO/H/EL</p>	10/13/16	

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F 281	Continued From page 8 *The signing of the death certificate was to be completed by a physician, physician assistant, or nurse practitioner. *The signing of the death certificate cannot be delegated to anyone else. *A licensed nurse cannot pronounce death.	F 281		
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. (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. (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.	F 441	#1 Resident #16 discharged AMA on 9/9/16 with no sign/sx of infection. Resident #10 discharged on 9/9 with no sign/sx of infection ^{omit} sign/sx of infection. Resident #7 assessed for sign/sx of infection, none noted. Resident #10 had no PU and resident #7 no gastrostomy. Resident #3 has both, assessed with no sign/sx of infection. #2 Any resident with wound care has potential to be affected if infection control policy not followed for wound care. #3 On September 21 + 22 education will be provided ^{by the} to all staff on the policy ^{DCN.} for hand washing and ^{NR-15DD04EL} the nurses will be educated on the policy for dressing changes and the handwashing/gloving that is required. ^{*On September 21 and 22 by} Review of the current policy ^{DCN.} covers all necessary items ^{NR-15DD04EL} to maintain infection control.	

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F 441	Continued From page 9 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Surveyor: 36413 Based on observation, interview, and policy review, the provider failed to ensure handwashing was done after the removal of gloves for three of four observed residents (7, 10, and 16) dressing changes by random observed licensed nursing staff (B and C). Findings include: Surveyor: 35121 1. Observation on 8/23/16 at 10:03 a.m. of licensed practical nurse (LPN) B during a dressing change of resident 16's left foot wound revealed she: *Removed the soiled dressing with gloved hands. *Discarded the soiled dressing in a plastic bag. *Cleaned the wound without touching the wound bed. *Removed her gloves and discarded them into the plastic bag. *Did not wash her hands. *Put on new gloves. *Applied topical medication and a new dressing. *Removed her gloves and discarded them. *Did not wash her hands. *Applied a sock and sheepskin boot to his foot. *Placed the plastic bag with soiled items inside another plastic bag. *Washed her hands.	F 441	#4 Return demonstrations on handwashing will be conducted randomly on 5 staff per week times 4 weeks by Director of Nursing or designee. Return demonstrations on dressing changes (including handwashing & gloving) will be completed by all nurses by 10/13/16, by Director of Nursing or designee. #5 All findings from return demonstrations will be reported to QAPI *by DON NR/SDDOHH/EL with trends or negative findings action planned. *Audits will be reported to QAPI until QAPI decides the issue is resolved. NR/SDDOHH/EL	10/13/16

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F 441	<p>Continued From page 10</p> <p>Surveyor: 36413</p> <p>2. Observation on 8/23/16 at 11:28 a.m. with LPN B during change of resident 10's pressure ulcer wound dressing revealed she:</p> <ul style="list-style-type: none"> *Removed the soiled dressing with gloved hands. *Discarded the soiled dressing into a plastic bag. *Cleaned the wound with saline in a syringe while touching wound with end of syringe. *Removed her gloves and discarded in plastic bag. *Took gloves out of pocket and put on new gloves. *Did not wash hands. *Cleaned scissors from her pocket with alcohol wipes. *Covered the wound with a dressing and a medicine that promotes healing. *Removed her gloves and discarded into the plastic bag. *Removed dressing from her drawer in her room. *Cut dressing to size. *Took gloves out of her pocket and put them on. *Did not wash her hands. *Put dressing on wound. *Removed her gloves. *Did not wash her hands. *Put on her incontinent brief without gloves. *Repositioned resident in the bed. *Washed her hands. <p>Surveyor: 35121</p> <p>3. Interview on 8/23/16 at 11:18 a.m. and at 11:35 a.m. with the director of nursing revealed:</p> <ul style="list-style-type: none"> *She would have expected LPN B to have washed her hands or used alcohol hand gel each time she had removed her gloves. *LPN B had not followed their hand washing or dressing change policies. 	F 441			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435009	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/24/2016
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MILBANK			STREET ADDRESS, CITY, STATE, ZIP CODE 1103 SOUTH SECOND STREET MILBANK, SD 57252	
(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 441	<p>Continued From page 11 Surveyor: 36413 4. Observation on 8/23/16 at 11:43 a.m. of registered nurse (RN) C during a dressing change of resident 7's gastrostomy tube revealed she: *Washed her hands and put on her gloves. *Wiped off around the tube with saline. *Removed her gloves. *Did not wash her hands. *Tore tape for the dressing change. *Removed new gloves from her pocket and put them on. *Applied a dressing around the tube. *Removed her gloves. *Did not wash her hands. *Applied tape to dressing. *Washed her hands.</p> <p>Surveyor: 35121 Review of the provider's revised August 2014 Handwashing/Hand Hygiene policy confirmed they were to wash their hands with soap and water or rub hands with an alcohol-based gel: **"Before and after direct contact with residents." **"After contact with a resident's intact skin." **"After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident." **"After removing gloves."</p> <p>Review of the provider's 2/4/16 Dressing Change, Clean policy confirmed they were to have followed the following steps: *Remove soiled dressing and discard in plastic bag. *Perform hand hygiene. *Put on second pair of gloves. *Cleanse wound. *Apply medications and dressings.</p>	F 441		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435009	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/24/2016
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MILBANK		STREET ADDRESS, CITY, STATE, ZIP CODE 1103 SOUTH SECOND STREET MILBANK, SD 57252		
(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 441	Continued From page 12 *Remove gloves and discard in plastic bag. *Wash hands.	F 441		

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

ORIGINAL

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435009	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/24/2016
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MILBANK			STREET ADDRESS, CITY, STATE, ZIP CODE 1103 SOUTH SECOND STREET MILBANK, SD 57252	
(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>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 8/24/16. Golden LivingCenter - Milbank was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for Existing Health Care Occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000		

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

Rich Freeman

TITLE

ED

(X6) DATE

9/14/16

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.

