STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195591	A. BUILDING _____ B. WING _____	C 11/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST JEFFERSON HEALTH CARE CENTER	1020 MANHATTAN BLVD HARVEY, LA 70058

(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 000	INITIAL COMMENTS Complaints #LA00056062 and #LA00056222 and #LA00056207. An unrelated tag F610 was cited as a result of complaint #LA00056222. A COVID-19 Focused Infection Control Survey was conducted on 11/04/2020. The facility was found to be in compliance with 42 CFR 483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended Practices to prepare for COVID-19. Total Residents: 101	F 000		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record	F 610	1. During investigation it was determined	12/18/20

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F 610	Continued From page 1 review, the facility failed to ensure an injury of unknown origin was reported and thoroughly investigated. The deficient practice was identified for 1 (Resident #1) of 8 sampled residents, and had the potential to affect any of the 100 Residents who resided in the facility as documented on the Alphabetical Resident Census list. Findings: Review of Resident # 1's record revealed the resident was admitted to the facility on 03/03/2020, with diagnosis in part, Dysphagia; Stroke; Epilepsy, unspecified, intractable with status epilepticus; Degenerative disease of nervous system; Unspecified, abnormal involuntary movement; Unspecified abnormalities of gait and mobility. Review of Resident # 1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/23/2020 revealed , in part Resident # 1 had a Brief Interview of Mental Status (BIMS) score of 4 which indicated a decline in cognitive function. Further review revealed Resident # 1 had no documented behaviors in the 7 day prior assessment period. Further review revealed Resident # 1 received antipsychotic, antianxiety, and antidepressant medications in the 7 day prior assessment period. Review of resident #1's Weekly Skin Integrity Review dated August 2020 to October 2020 revealed, in part, on 9/9/2020, lower limb with yellow and green bruising, skin intact; 9/22/2020, lip enlarged and purple, the left and right eye purple. S3/LPN further revealed she was not sure what happened and reported her findings to S5/Former Assistant Director of Nursing who	F 610	that injuries resulted from a seizure. An incident was completed on Resident #1 to reflect those findings. 2. All residents had the potential to be affected. However, an audit of incident reports begin on 11-06-2020 to ensure proper documentation and to ensure that further investigation was not needed. If discrepancies are found the Physician and family were be immediately notified. 3. Nursing staff has been re-educated on incidents reporting and investigating. In-service stated that DON must be notified of all incidents along with Physicians and family members. All notifications must be documented on incident report in the proper place. 4. DON or designee will monitor incidents 5 days a week x 4 weeks, then 3 times a week for 2 weeks then randomly as deemed necessary by Administrator. DON will document review by signing investigation sheets. Any concerns identified will be corrected and handled accordingly . Results will be discussed in the morning QA weekly.	

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F 610	Continued From page 2	F 610		

informed her that an incident report was already completed by the S4/LPN nurse 10/05/2020, discoloration on legs and arms; 10/22/2020 in hospital; 10/29/2020, skin intact.

Review of Emergency Procedure- Seizure Management policy revealed, in part, personnel will assist in safety measures for resident who is having a seizure. For residents with identified risk of seizures, screen residents and note any situations that precipitate seizures. The emergency procedure include monitoring vital signs every 15 minutes for at least two hours following seizure activity, and then as ordered by physician. The physician should be notified during or as soon as possible after the seizure, and subsequently notify the family of the event.

Review of facilities Statewide Incident Management System (SIMS) report log for August 2020 to October 2020 revealed there was no documented evidence that a SIMS report was submitted for Resident #1.

Review of Nursing Look Back Assessment Notes dated 09/18/2020 to 09/23/2020 revealed no documented evidence of resident #1 having seizure activity or any falls.

Review of S4/LPN Nurse's Notes dated 09/22/2020, 6A-10P revealed in part, resident awake AAOx3, confused and forgetful at times with delayed response. Per documentation, Resident # 1 had dark purplish/ blackness to right eye. Resident#1 stated, "I don't know" when asked what happened. Further documentation revealed S4/LPN "applied ice for comfort." Further review of the nurse's notes dated 09/22/2020 revealed no documentation of the

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F 610	Continued From page 3	F 610		

physician being notified of a change in resident's condition and no documented evidence of post seizure activity neuro-checks.

Review of the nurse's notes for Resident #1 on 9/22/2020 at 2230 revealed the Resident had minimal swelling to his lower lip with redness.

In an interview on 11/05/2020 at 3:15 PM S7/Director of Operations verified no incident or accident reports were documented for Resident #1 during the months of August 2020 - October 2020. She further indicated that the S5 ADON is no longer working at the facility and the requested information for reports associated with event on 09/22/2020 when resident#1 was observed by nurse to have " a dark purplish/ blackness to right eye," cannot be located at this time.

In an interview on 11/06/2020 at 8:30 AM, S6/RN, revealed she works doubles on the weekend and remember seeing resident#1 "with big black eye, everyone was drawing attention to the injury, and was not sure what happened."

In a telephone interview on 11/06/2020 at 1:25 PM, S7/MD, when asked if he was informed of resident#1's black eyes and swollen lip that was identified on 09/22/2020, he stated, "I don't recall but I should have been notified if something like that happened."

In a joint interview on 11/06/2020 at 12:15 pm, S1 /Administrator, and S2/Interim DON, the administrator stated she was unaware of Resident#1's sustaining bilateral black eyes and a swollen lip on 09/22/2020. The administrator recalled a discussion in the morning meeting on 09/23/2020 of resident #1 having a suspected

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F 610	Continued From page 4 seizure but stated but no one informed her of resident #1 having bilateral black eyes and a swollen lip. She confirmed she should have been informed of Resident #1's black eyes and swollen lip. When surveyor questioned her regarding S3 reporting the incident to the former S5/ADON, she stated the S5/ADON was no longer working at the facility. The S2/Interim DON confirmed she was unable to locate any incident reports or documentation regarding resident#1's black eyes and swollen lips. The administrator stated S5/ADON should have reported Resident #1's black eyes and swollen lip to her and she would have started an investigation and open a SIMS report. She confirmed no report was filed and no investigation was done. The S2/Interim DON stated the physician should have been notified of Resident#1's change in condition and neuro-checks should have been started. The S2/Interim DON confirmed there was no documented evidence of neuro-checks pertaining to Resident #1's black eyes and swollen lip on 09/22/2020. S1/Administrator and S2/ Interim DON confirmed they were not sure of what happened to resident #1.	F 610		

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	195591	A. BUILDING _____ B. WING _____	C 02/28/2020

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F 000	INITIAL COMMENTS Complaint Survey #LA00054389	F 000		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview the facility failed to ensure 1 (Resident #1) of 5 residents received assistance to maintain good personal hygiene and oral hygiene. The facility had 97 residents who required assistance with ADLs as documented on the facility's List of Residents. Findings: Review of Resident #1's record revealed the resident was admitted to the facility on 07/27/2018 with diagnoses of multiple sclerosis, chronic pain, and muscle spasm. Review of Resident #1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/11/2020 revealed, in part: the resident required extensive assistance of two persons for bed mobility, transfers, and toilet use. Resident #1 required extensive assistance of one person for locomotion on an off the unit. Resident #1 was totally dependent of one personal for dressing, personal hygiene, and bathing. Further review revealed Resident #1 was always incontinent of bowel and bladder. Review of Resident #1's Care Plan with goal date	F 677	(1.)DON/ADON assured that Resident#1 was given a shower and ensured that it was documented. (2.)An audit was completed on 2-11-2020 utilizing a two week look back period to identify any other residents to be affected by the deficient practice. Several residents were identified. Once identified the documentation was updated to reflect the care received. (3.)A Bath Schedule was created which consisted of Women showers/ whirlpools being completed on Mon, Wed, Fri. and Men showers/whirlpools being completed on Tue, TH, and Sat. In-services were conducted with CNA□s on completing ADL□s and proper ways to document the completion of ADL□s. Nurses were in-serviced on checking documentation on ADL□s prior to their shift ending on daily basis. All completed ADL□s will be logged on to CNA Flow Sheet (Monitoring tool). (4.) Completed ADL□s Flow sheets will be monitored daily by morning and evening nurse daily. DON/Designee will monitor 5 days per week once a day for 6 weeks and log onto monitoring tool. Completion	4/10/20

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F 677	Continued From page 1 of 05/10/2020 revealed in part; Resident #1 had a ADL (Activities of Daily Living) self-care deficit as evidenced by the resident needed assistance with, in part: bed mobility, transfers, walking, locomotion, dressing, eating, toilet use, personal hygiene and bathing related to multiple sclerosis and chronic pain. Further review revealed approaches, in part: report changes in ADL self-performance to the nurse; and provide only the amount of assistance/supervision that was needed. In an interview on 02/27/2020 at 12:04pm, Resident #1 stated she had not brushed her teeth today and had not gotten a shower today. Resident #1 was asked when was the last time she had her teeth brushed or a shower and Resident #1 stated she did not get a shower or brush her teeth today or yesterday. Observation on 02/27/2020 at 3:24pm of Resident #1's body audit revealed, in part: the bottom half of the resident's toenail to the right great toe was black with blue stitches to each side of the toenail. Further observation revealed the resident was heavily soiled with urine. Review of Resident #1's Nurses Notes dated 12/24/2019 revealed Resident #1's toenail, to the right great toe, was stitched. In an interview on 02/28/2020 at 10:35am, Resident #1 stated she was not bathed today. Review of Resident #1's CNA Flow Sheet for December 2019 revealed, in part: the only dates any bath, shower, whirlpool was documented was on 12/11/2019, 12/12/2019, 12/21/2019; and a refusal on 12/30/2019. Review revealed all other	F 677	of ADL□s will continue to be monitored thereafter and checked PRN by DON/Designee. Any concerns identified will be corrected and handled accordingly by DON/Designee. Monitoring will be reviewed in quarterly	

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F 677	Continued From page 2	F 677		

dates in December 2019 had a "N" documented for none given for bath or was left blank. Further review revealed no oral care was documented on 12/20/2019 and 12/22/2019.

Review of Resident #1's CNA Flowsheet for January 2020 revealed, in part: the only dates any bath, shower, or whirlpool was documented was on 01/10/2020 for a shower, 01/22/2020 for a shower, and bath on 01/23/2020 and 01/31/2020. Further review revealed all other dates were documented as "N" for none given or left blank with no documentation.

Review of Resident #1's CNA Flowsheet for February 2020 revealed, in part: the only dates any bath, shower, or whirlpool was documented was on 02/01/2020 a bath. Review revealed all other days were marked "N" for none given or left blank. Further review revealed no oral care was documented on 02/03/2020, 02/08/2020, 02/16/2020, and 02/18/2020.

In an interview on 02/28/2020 at 10:56am, S3Shower CNA (Certified Nursing Assistant) stated she could not remember ever giving Resident #1 a shower or whirlpool. S3Shower CNA stated she did not have any documented evidence of providing a shower or whirlpool to Resident #1

In an interview on 02/28/2020 at 11:12am, S4CNA stated she had been taking care of Resident #1 for about a month. S4CNA stated the resident gets a shower once to twice a week and a bed bath every day. S4CNA stated the resident will refuse baths, showers, and whirlpool sometimes. S4CNA stated the resident allowed nail care and allowed oral care to be performed.

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F 677	Continued From page 3	F 677		

The surveyor then asked S4CNA when her last bed bath was and S4CNA stated yesterday. The surveyor then asked if she had removed all the residents clothing including socks to bath her and S4CNA stated yes. The surveyor then asked S4CNA if she had noticed anything different about her feet or toenails and S4CNA stated she had not noticed anything different about Resident #1's feet or toenails and everything was normal. S4CNA was told about the stitches to Resident #1's great toe and she stated she never noticed. S4CNA stated she documented all ADL care provided in the facility's ADL book and the shower aide will document the showers provided. S4CNA then reviewed the ADL book and stated she did not document every time she gave Resident #1 a bed bath. S4CNA stated she did not document having gave the resident bed baths. S4CNA further stated for oral care documentation she had only initialed and did not document if the oral care was completed.

In an interview on 02/28/2020 at 11:20am, S5LPN (Licensed Practical Nurse) stated she did not personally check with the CNA staff to ensure ADLs were provided because they were all adults and expected to do the job. S5LPN stated she did not check the CNA flow sheets to ensure the care was provided.

In an interview on 02/28/2020 at 11:32am, S2DON (Director of Nursing) stated the facility did not have CNA supervisor and the facility did not have anyone assigned to check the ADL flow sheets on a daily basis to ensure care was being provided. S2DON stated she does check the ADL flow sheet book periodically, but not on a daily basis. S2DON stated the nurses were responsible for ensuring the ADL care was

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F 677	Continued From page 4 provided and documented. S2DON was informed about the CNA having stated she provided a bed bath, and having provided bed baths during the last months, however not knowing she had a right great toe injury with stitches to the toenail. S2DON stated if the CNA did provide bed baths she would have known about Resident #1's toe injury and stitches to the toenail. S2DON further stated, after reviewing the ADL binder, that Resident #1 was not receiving ADL per the plan of care.	F 677		

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	195591	A. BUILDING _____ B. WING _____	C 04/21/2020

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F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on April 21, 2020. The facility was found to be in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Complaint LA00054772 No deficiencies cited as a result of this complaint. Total Residents: 98	F 000		

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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 000}	INITIAL COMMENTS A desk review was conducted for previous deficiency cited on 02/28/2020. Deficiency was cleared. Complaint Survey #LA00054389	{F 000}		

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	195591	A. BUILDING _____ B. WING _____	06/22/2020

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F 884 SS=F	Reporting - National Health Safety Network CFR(s): 483.80(g)(1)(i)-(ix)(2) §483.80(g) COVID-19 reporting. The facility must-- §483.80(g)(1) Electronically report information about COVID-19 in a standardized format specified by the Secretary. This report must include but is not limited to- (i) Suspected and confirmed COVID-19 infections among residents and staff, including residents previously treated for COVID-19; (ii) Total deaths and COVID-19 deaths among residents and staff; (iii) Personal protective equipment and hand hygiene supplies in the facility; (iv) Ventilator capacity and supplies in the facility; (v) Resident beds and census; (vi) Access to COVID-19 testing while the resident is in the facility; (vii) Staffing shortages; (viii) The COVID-19 vaccine status of residents and staff, including total numbers of residents and staff, numbers of residents and staff vaccinated, numbers of each dose of COVID-19 vaccine received, and COVID-19 vaccination adverse events; and (ix) Therapeutics administered to residents for treatment of COVID-19. §483.80(g)(2) Provide the information specified in paragraph (g)(1) of this section at a frequency specified by the Secretary, but no less than weekly to the Centers for Disease Control and Prevention ' s National Healthcare Safety Network. This information will be posted publicly by CMS to support protecting the health and safety of residents, personnel, and the general	F 884		6/22/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 06/22/2020

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195591	A. BUILDING _____ B. WING _____	06/22/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST JEFFERSON HEALTH CARE CENTER	1020 MANHATTAN BLVD HARVEY, LA 70058

(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 884	Continued From page 1 public. This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to report complete information about COVID-19 to the Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN) during a seven-day period that reporting was required by regulation. The CDC submitted data from the NHSN to the Centers for Medicare and Medicaid Services (CMS). Based on review of that data, CMS determined that between 06/08/2020 and 06/21/2020, the facility did not report complete information to NHSN about COVID-19 in the standardized format and frequency as specified by CMS and the CDC. This failure to report has the potential to cause more than minimal harm to all residents residing in the facility.	F 884		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195591	A. BUILDING _____ B. WING _____	06/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST JEFFERSON HEALTH CARE CENTER	1020 MANHATTAN BLVD HARVEY, LA 70058

(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 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was conducted on 06/29/2020. The facility was found to be in compliance with 42 CFR 483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended Practices to prepare for COVID-19. Total Residents: 99	F 000		

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

Electronically Signed | 08/05/2020

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195591	A. BUILDING _____ B. WING _____	07/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST JEFFERSON HEALTH CARE CENTER	**1020 MANHATTAN BLVD HARVEY, LA 70058**

(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 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was conducted on 07/14/2020. The facility was found to be in compliance with 42 CFR 483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended Practices to prepare for COVID-19. Total Residents: 98	F 000		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195591	A. BUILDING _____ B. WING _____	08/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST JEFFERSON HEALTH CARE CENTER	**1020 MANHATTAN BLVD HARVEY, LA 70058**

(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 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was conducted on 08/19/2020. The facility was found to be in compliance with 42 CFR 483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended Practices to prepare for COVID-19. Total Residents: 91	F 000		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.