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

PRINTED: 03/29/2019 FORM APPROVED OMB NO. 0938-0391

NAME OF PROMOTER OR SUPPLIER  NAME OF PROMOTER OR SUPPLIER  SIMULATIVE TO ROUGH HOME  SUMMANY CHATEMENT OF DEPOSACIOES  OWN ID.  OWN ID.  OWN ID.  OWN ID.  INITIAL COMMENTS  THIS FACILITY IS IN COMPLIANCE WITH THE COORD INTERMEDIATION FOR INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES FOUNDAT 42 CFR 483.480  (IGENERAL/HEALTH REQUIREMENTS).  ABONALORY DIRECTIONS OF PROVIDERSUMPAUER REPRESENTATIVES SIGNALUVE  ABONALORY DIRECTIONS OF PROVIDERSUMPAUER REPRESENTATIVES SIGNALUVE  TILLE  ONLY THE COORDINATION OF PROVIDERSUMPAUER REPRESENTATIVES SIGNALUVE  INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES FOUNDAT 42 CFR 483.480  (IGENERAL/HEALTH REQUIREMENTS).	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
INTERCEDIATE OR SUMMARY STATEMENT OF DEFICIENCIES (EACH DETICIENCY MUST BE PRECEDED BY FULL RESULATION OR LIST DEFINITION INFORMATION)  W 000 INITIAL COMMENTS  THIS FACILITY IS IN COMPLIANCE WITH THE CONDITIONS OF PARTICIPATION FOR INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES FOUND AT 24 CPR 483.480 (GENERAL/HEALTH REQUIREMENTS).			34G258	B. WING _	B. WING		03/20/2019	
PREFIX TAG REGULATORY OR ISC IDENTIFYING INFORMATION)  W 000  INITIAL COMMENTS  THIS FACILITY IS IN COMPLIANCE WITH THE CONDITIONS OF PARTICIPATION FOR INTERMEDIATE CARGE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES FOUND AT 42 CFR 483-400 THROUGH 483-460 AND 42 CFR 483-480 (GENERAL/HEALTH REQUIREMENTS).					406 IOTLA STREET	ET ADDRESS, CITY, STATE, ZIP CODE OTLA STREET		
THIS FACILITY IS IN COMPLIANCE WITH THE CONDITIONS OF PARTICIPATION FOR INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES FOUND AT 42 CFR 483.400 THROUGH 483.460 AND 42 CFR 483.480 (GENERAL/HEALTH REQUIREMENTS).	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
A ADDRATORY DIDECTORIO OD DROVIDEDIOLIDO DE DECONITATION DE CONTRATORIO DE CONTRA		(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  INITIAL COMMENTS  THIS FACILITY IS IN COMPLIANCE WITH THE CONDITIONS OF PARTICIPATION FOR INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES FOUND AT 42 CFR 483.400 THROUGH 483.460 AND 42 CFR 483.480						

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.