

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155249	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/19/2015
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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: October 13, 14, 15, 16, and 19, 2015</p> <p>Facility number: 000153 Provider number: 155249 AIM number: 100266910</p> <p>Census bed type: SNF/NF: 75 Total: 75</p> <p>Census Payor type: Medicare: 4 Medicaid: 65 Other: 6 Total: 75</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed on October 20, 2015 by 17934.</p>	F 0000		
F 0280 SS=D Bldg. 00	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged</p>			

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.

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	<p>incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on record review and interview, the facility failed to ensure physician's orders to obtain a lab test were followed for 1 of 5 residents (#16) reviewed for medications.</p> <p>Findings include:</p> <p>Resident # 16's medications were reviewed on 10/19/15 at 9:00 A.M. The physician's orders of 9/17/15 indicated to change Coumadin (a blood thinning medication) to 3.0 milligrams a day and to obtain a Prothrombin Time/International Ratio (PT/INR) lab test, in one week on 9/24/15. The next PT/INR was completed on 10/13/15.</p> <p>An interview with the Assistant Director</p>	F 0280	<p>F280 Based on record review and interview, the facility failed to ensure physician's order to obtain a lab test were followed for 1 of 5 residents review for medications:</p> <p>1. The following corrective actions will be accomplished for those residents found to be affected by the deficient practice; Audit completed 10/20/15 of 100% of residents laboratory orders from the past 30 days to ensure orders are completed and laboratory requisitions are completed.</p> <p>1. Other residents having the potential to be affected by the same deficient practice will be identified through corrective actions including; Daily audit during clinical meeting to ensure all new laboratory orders are placed on the White Board for monitoring of laboratory results</p>	11/06/2015

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F 0329 SS=D Bldg. 00	<p>of Nursing (ADN) on 10/19/15 at 10:44 A.M. indicated the order for Resident #16's PT/INR lab test to be completed on 9/24/15 was missed. The ADN indicated when it was noted on 10/13/15 the PT/INR was missed, a physician's order was obtained to draw the lab STAT. The lab results indicated the PT/INR was in the desired range.</p> <p>3.1-35(c)(1)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to</p>		<p>and follow through.</p> <p>1.Measures that will be put into place to ensure that the deficient practice does not recur include; Bi-weekly audit of individualPT/INR orders have been completed, obtain of result and new medication ordersreceived and carried out.</p> <p>1.Weekly audit during At Risk meeting to review Coumadin logs are completed and up to date. Weekly audits will be taken through QAPI monthly to ensure continued compliance.</p>	

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	<p>treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to demonstrate adequate indications for increasing an anti-psychotic medication for 1 of 5 residents reviewed for unnecessary medications (Resident #58).</p> <p>Findings include:</p> <p>The record for Resident #58 was reviewed on 10/15/2015 at 3:15 P.M. Diagnoses included, but were not limited to, dementia with hallucinations. A physician's order sheet, dated 9/30/2015, indicated Resident #58 was prescribed clozapine (medication used to treat psychosis) 25 mg (milligrams) daily at bedtime and clozapine 12.5 mg daily at noon.</p> <p>A nursing progress note, dated 8/27/2015 at 11:52 P.M., indicated Resident #58 had become upset in the main dining room about "children running around under the tables." The note indicated the resident stated the meal was "horrible" and he just wanted to get out of the</p>	F 0329	<p>F329 Drug regimen is free from unnecessary drugs</p> <p>1. The following corrective actions will be accomplished for those residents found to be affected by the deficient practice; Audit completed 11/3/15 of 100% of psychotropic drug use to ensure all have proper diagnosis and have up to date GDR.</p> <p>1. Other residents having the potential to be affected by the same deficient practice will be identified through corrective actions including; Weekly audit of behavior management logs to ensure proper documentation is present to validate the need for medication x2 months, then monthly audits x2 months.</p> <p>1. Measures that will be put into place to ensure that the deficient practice does not recur include; Monthly behavioral meeting to continue and prior to change in medications, the Physician and Pharmacist will review the behavioral management logs to ensure proper documentation are present before changes are made.</p> <p>4. The corrective actions will be monitored to ensure the deficient practice does not recur by presenting the findings at the</p>	11/12/2015

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	<p>dining room. The note further indicated the resident was assisted back to his room as requested. The note indicated the resident later apologized and there were no further behaviors.</p> <p>A nursing progress note, dated 9/2/2015 at 10:27 A.M., indicated Resident #58 exhibited increased confusion and had become irritated while the staff was assisting him with toileting. The resident indicated he was upset because he did not have his normal room. There were no other concerns documented.</p> <p>A nurse practitioner progress note, dated 9/18/2015, indicated "Nursing and resident report no concerns". The note further indicated "oriented to person and place. Has periods of confusion." The note also indicated "Continue plan of care, meets resident needs."</p> <p>A "Behavior/Intervention Monthly Flow Record" for September 2015 indicated Resident #58 was being monitored for signs and symptoms of depression and signs and symptoms of hallucinations. The flow sheet did not indicate Resident #58 had exhibited any signs or symptoms of depression or hallucinations in September 2015.</p> <p>A physician order, dated 9/25/2015,</p>		<p>monthly QA/PI meeting for further review and/or action.</p> <p>A re-education in-service will beheld on 11/12/15 to review proper documentation of behavior management logswith 100% of Nurses.</p> <p>5. In-service to be held on 11/12/15 to re-educate 100% of all staff on the importance of updating the nurse when behaviors are noted.</p>	

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	<p>indicated Resident #58's clozapine was increased from 25 mg at bedtime to an additional dose of 12.5 mg at noon for hallucinations.</p> <p>There was no other documentation in the record to indicate the resident had experienced any other behaviors related to hallucinations or delusions in September 2015, before the clozapine was increased on 9/25/2015.</p> <p>RN #3 was interviewed on 10/19/2015 at 9:45 A.M. During the interview RN #3 indicated the facility used data collected on the "Behavior/Intervention Monthly Flow Record", nursing progress notes, and information shared by staff to make decisions regarding adjustments in a resident's psychotropic medications.</p> <p>Review of the Nursing 2014 Drug Handbook included the following for clozapine: "Black box warning: Drug isn't indicated for use in elderly patients with dementia related psychoses because of an increased risk for death from CV (Cardiovascular) disease or infection..."</p> <p>3.1-48(a)(3)</p>			

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F 0371 SS=E Bldg. 00	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview and record review, the facility failed to ensure foods were stored in the pantry and kitchen area to meet sanitary conditions. The facility further failed to ensure the food preparation areas were free of dust and food hazards. This had the potential to affect 71 of 75 residents residing in the facility.</p> <p>Findings include:</p> <p>During initial census identification, on 10-13-2015, at 10:20 AM, the Director of Nursing identified the census as being 75, with 4 residents utilizing tube feeding as their total nutritional support.</p> <p>1. During the kitchen/ pantry tour on 10-13-2015 at 10:32 AM, in Emergency</p>	F 0371	<p>F371 / SS=E Based on observation, interview and record review, the facility failed to ensure foodswere stored in the pantry and kitchen area to meet sanitary conditions. The facility further failed to ensure thefood preparation areas were free of dust and food hazards.</p> <p>1.The following corrective actions will beaccomplished for those residents found to be affected by the deficientpractice; 1.Anaudit was completed 10/19/15 on 100% of food stock in the pantry identified to ensurethe expiration date had not been exceeded 2.Themicrowave oven in the B-wing pantry was cleaned 10/19/15 by the Director ofHousekeeping. 3.Allshakes in question were immediately disposed of 10/19/15 to ensure residentwell-being. 4.TheMaintenance Director cleaned the ceiling vent identified</p>	11/12/2015

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	<p>food supply, two 7 pound cans of Cranberry with use by dates of 7-30-15 were observed. Additionally, two 11 ounce cans of La Choy egg noodles with use by dates of 8-16-2015 were observed.</p> <p>In an interview on 10-13-2015 at 10:34 AM, the CDM (Certified Dietary Manager) indicated the Emergency food supply was reviewed every 6 months to prevent expiration.</p> <p>A document dated 10-14-2015 was provided by the CDM on 10-15-2015 at 10:04 AM. The document indicated an audit of Stock room Emergency Supply had been completed on 10-14-2015.</p> <p>During an observation on 10-13-2015 at 10:45 AM, the B wing pantry microwave had orange and yellow spots on the top of the inside that could be removed when rubbed. Additionally, the C wing microwave had yellow spots that could be removed by rubbing on the top of the inside.</p> <p>In an interview on 10-13-2015 at 10:45 AM, CNA #1 indicated the staff were to clean up after themselves, but there was no cleaning schedule for the microwave.</p> <p>During an observation on 10-13-2015 at 11:02 AM, the C wing pantry was</p>		<p>10/15/15.</p> <p>1. Other residents having the potential to be affected by the same deficient practice will be identified through corrective actions including;</p> <p>1. An audit was completed 10/19/15 on 100% of food stock in the pantry to ensure the expiration date had not been exceeded.</p> <p>2. The microwave oven in the B-wing pantry was cleaned immediately 10/19/15 by the Director of Housekeeping.</p> <p>3. All shakes in question were immediately disposed of 10/19/15 to ensure resident well-being.</p> <p>4. The Maintenance Director immediately cleaned the ceiling vent identified 10/15/15.</p> <p>3. Measures that will be put into place to ensure that the deficient practice does not recur include;</p> <p>a. The Dietary Director/ or designee will audit the emergency food supply for expired products; weekly x4 weeks, bi-weekly x8 weeks, then monthly thereafter.</p> <p>b. The Housekeeping Director / or designee will audit the cleanliness of the microwave ovens in the facility; weekly x4 weeks, bi-weekly x8 weeks, then monthly thereafter.</p> <p>c. All nursing personnel will be educated 11/12/15 on proper procedure for dating health shakes while they are thawing.</p>		

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	<p>observed to have 8- 4 ounce chocolate shakes in the refrigerator, not frozen, and not labeled with thaw dates.</p> <p>A review of the Chocolate shake carton indicated: Store frozen, thaw under refrigeration, and use within 14 days. Additionally, there was a space provided for the thaw date.</p> <p>In an interview 10-13-2015 at 11:02 AM, LPN #2 indicated she didn't know the shakes were to be labeled when thawed. " Rotating stock was not addressed for Emergency Food Storage."</p> <p>A current, undated policy titled Food Storage provided by the Administrator on 10-15-2015 at 10:04 AM indicated "10. All stock must be rotated with each new order received."</p> <p>2. During the kitchen tour on 10-13-2015 at 10:32 AM, the ceiling vent over prep area was observed to have gray, fuzzy areas on the corners of the fan, extending 6 inches onto the ceiling area surrounding the fans.</p> <p>In an interview on 10-13-2015 at 11:12 AM, the CDM Indicated the vents had been cleaned 2 weeks ago.</p> <p>A work history report dated 09-30-2015</p>		<p>Unit Manager/ or designee will audit thehealth shakes weekly x4 weeks, then monthly thereafter to ensure compliance.</p> <p>d. The Maintenance Director / or designee will audit kitchen ceiling ventsto ensure that they are free of dust and debris; weekly x4 weeks, bi-weekly x8weeks, then monthly thereafter.</p> <p>4. Thecorrective actions will be monitored to ensure the deficient practice does notrecur by presenting the findings at the monthly QA/PI meeting for furtherreview and/or action.</p> <p>5. Thesystemic changes will be completed by 11/12/15.</p>	

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F 0465 SS=E Bldg. 00	<p>provided by the Director of Maintenance on 10-14-2015 at 9:11 AM, indicated the exhaust fans were inspected on 9-18-2015. There was no indication the fans had been cleaned.</p> <p>In an interview on 10-14-2015 at 9:11 AM, the Administrator indicated Maintenance inspected air vents with the exhaust fans.</p> <p>3.1-21(i)(1)(2)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation, interview and record review, the facility failed to maintain paint on walls, closet and bathroom doors in 19 of 76 resident rooms; failed to maintain the finish for 3 of 75 overbed tables; failed to maintain the finish and filter placement for 5 of 76 room heaters; failed to maintain the veneer in good repair on 3 of 8 cabinets in the Serenity unit; and failed to maintain facility furniture in good repair</p>	F 0465	<p>F465 / SS=E Basedon observation, interview and record review, the facility failed to maintainpaint on walls, closet, and bathroom doors, failed to maintain the finish ofoverbed tables, failed to maintain the finish and filter placement of roomheaters, failed to maintain veneer in good repair on cabinets on Serenity Unit,and failed to maintain facility furniture in good repair.</p> <p>1.The following corrective actions will be accomplished for those residents found to be</p>	11/06/2015

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	<p>on the Serenity unit and in the main dining area.</p> <p>Findings include:</p> <p>1. During an Environmental tour on 10-15-2015 at 9:15 AM, the following was observed:</p> <p>In room 101, the room door had peeling paint across the width of the door about 12 inches from the floor, additionally, the bathroom door had peeling paint across the width of the door about 12 inches up from the floor.</p> <p>In room 103, the bathroom door had peeling paint about 12 inches from the floor about 1/4 inch wide across the width of the door.</p> <p>In room 106, the bathroom door had peeling paint about 12 inches from the bottom of the door, across the width of the door.</p> <p>In room 109, numerous white spots were noted behind the toilet.</p> <p>In room 111, numerous white spots were noted behind the toilet.</p> <p>In room 112, 5 scratches were noted down the wall behind the bed about 1/2 inch x 6 inches.</p> <p>In room 123, the walls were gouged about 4 inches by 1/4 inch. There were 3 gouges.</p> <p>In room 130, numerous white spots were noted behind the toilet.</p>		<p>affected by the deficient practice;</p> <p>1. The Maintenance Director / or designee inspected 100% of resident furniture, walls and heaters in resident rooms 11/05/15 to identify items needing repair or replaced.</p> <p>1. Other residents having the potential to be affected by the same deficient practice will be identified through corrective actions including;</p> <p>1. The Maintenance Director / or designee inspected 100% of resident furniture, walls and heaters in resident rooms 11/05/15 to identify items needing repair or replaced.</p> <p>1. Measures that will be put into place to ensure that the deficient practice does not recur include;</p> <p>1. The Maintenance Director / or designee will audit the condition of resident furniture weekly x4 weeks, bi-weekly x8 weeks, and monthly x3 months. Department will then audit resident furniture condition monthly thereafter and present findings at monthly QA/PI meeting.</p> <p>1. The corrective actions will be monitored to ensure the deficient practice does not recur by presenting the findings at the monthly QA/PI meeting for further review and/or action.</p> <p>2. The systemic changes will be completed by 11/6/15.</p>	

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	<p>In room 131, paint was peeling on the bathroom door across the width of the door about 12 inches up and 1/2 inch wide.</p> <p>In room 133, numerous white spots were noted behind the toilet.</p> <p>In room 135, paint was peeling on the bathroom door about 3 inches x 1/4 inch across the width of the door.</p> <p>In room 136, the wall behind call light was gouged about 1 inch wide.</p> <p>Additionally, the bathroom door had paint peeling about 12 inches from the floor about 1/4 inch wide, across the width of the door.</p> <p>In room 137, the wall behind the bed was gouged about 1/4 inch x 4 inches.</p> <p>In room 210, the paint was peeling on the closet door in a 2 inch area, about 24 inches from the floor.</p> <p>In room 221, gouges about 1/2 inch wide x 5 inches long were noted at the head of the bed.</p> <p>In room 223, numerous white spots were noted behind the toilet. The paint on the closet door was peeled in an area about 3 inches x 5 inches. Additionally, the closet door paint was peeling in 4 areas about 4 inches x 4 inches.</p> <p>In room 227, the room door paint was peeling about 10 x 1 inch vertically. The paint on the wall behind the bed was gouged about 2 inches x 5 inches. There were 4 scrapes about the same size.</p>			

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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815
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	<p>Additionally, the paint on the closet doors was peeling about 12 inches from the floor, the full width of the door.</p> <p>In room 229, the room door paint was peeling about 24 inches from the floor in several large patches.</p> <p>In room 236, numerous white spots were noted behind the toilet.</p> <p>In the common are of the Serenity unit, the wall behind the Lounge chair had 3 gouges 6 inches x 1/2 inch wide on the wall.</p> <p>In an interview on 10-16-2015 at 10:50 AM, the Maintenance Director indicated work orders were to be placed for areas needing attention or repairs.</p> <p>A review of work orders indicated only one work order had been filed in the last 90 days. The work order was dated 8-26-2015 for paint rubbed off at the head of the bed. There was no room number on the work order.</p> <p>In an interview on 10-16-2015 at 10:57 AM, the Maintenance Director indicated he looks at specific areas in building one time per month, but does not have a monthly or routine check on all the rooms.</p> <p>A review of completed work tasks without a date, provided by the Director</p>			

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	<p>of Maintenance on 10-16-2015 at 1:06 PM, indicated paint had been checked in the following rooms: 224, 126, 206, 201, 202, 200, 208, 108, 101, 206, 209, 235, 233, 222, 217, 132, and 110.</p> <p>A review of the Touch Up Painting Schedule dated 2015, provided by the Director of Maintenance on 10-16-2015 at 10:58 AM, indicated the rooms were touched up in June and July.</p> <p>2. In room 105, the over bed table had numerous scratches in the paint on the base of the unit. In room 106, the overbed table had numerous scratches in the paint on the base and upright too numerous to count. In room 123, the overbed table base and upright had scratches in the paint too numerous to count. In room 130, the overbed table had numerous scratches in the paint of the base and upright.</p> <p>In an interview on 10-16-2015 at 10:42 AM, the Maintenance Director indicated the facility was aware of the poor condition of the overbed tables.</p> <p>3. In room 103, the room heater filter was apart from the heater and laying on the floor. In room 111, the room heater had paint</p>			

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	<p>gouged from the finish about 6 inches from the floor across the face of the heater, Additionally, the heater filter was half in the heater, with the front half on the floor of the room.</p> <p>In room 130, the room heating unit's paint was gouged about 6 inches from the floor, the entire width of the heater about 1/4 inch wide. Additionally, the heater filter was laying on the floor.</p> <p>In room 132, the filter to the room heater was on the floor.</p> <p>In room 231, the room heater's paint was gouged across the width of the heater about 10 inches from the floor and 1/2 inch wide. Additionally, the heater filter was loose and laying on the floor.</p> <p>On the Serenity unit, the wall heater in the kitchen area filter was on the floor. In the dining room, one baseboard heating unit unit was pulled completely away from the wall.</p> <p>In an interview on 10-15-2015 at 10:42 AM, the Maintenance Director indicated "that's the way these heaters are made- there's nothing to keep the filter in place." He further indicated he replaced the filters as often as he saw the filters on the floor, but there was no daily check. Additionally, when staff see things needing to be fixed, they are to file a work order.</p>			

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	<p>4. On the Serenity unit, the veneer on kitchen area cabinets was loose and peeling in 4 areas about 4 inches x 1 inch towards the bottom of the doors of the cabinet.</p> <p>In an interview on 10-16-2015 at 10:12 AM, LPN #2 indicated the veneer had been peeling for a long time, and she did not know if a work order had been filed.</p> <p>5. In room 104, the room chairs had scarred legs, and the finish was peeling. On the Serenity unit, in the common area, the tables and chairs were marred with multiple gouges, and scratches were observed on 10 of the chairs with the finish on 5 tables being worn to the original wood around the edge on the tops.</p> <p>In the Main Dining area, 9 old dining room chairs had multiple gouges, and worn finishes down to the original wood.</p> <p>In an interview on 10-15-2015 at 1:10 PM, the Director of Maintenance indicated the facility had new chairs for the dining room, but was unsure where they were located.</p> <p>3.1-19(f)</p>			

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

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