

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155357	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/10/2015
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NAME OF PROVIDER OR SUPPLIER  RAWLINS HOUSE HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 300 J H WALKER DR PENDLETON, IN 46064
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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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F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaint IN00178242 and IN00178670.</p> <p>Complaint IN00178242- Substantiated. No Federal/State deficiencies cited.</p> <p>Complaint IN00178670 - Unsubstantiated due to lack of evidence.</p> <p>Survey date: August 10, 2015</p> <p>Facility number: 000248 Provider number: 155357 AIM number: 100291470</p> <p>Census bed type: SNF: 21 SNF/NF: 71 Total: 92</p> <p>Census payor type: Medicare: 21 Medicaid: 58 Other: 13 Total: 92</p> <p>Sample: 5</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	<p>The plan of correction is to serve as Rawlins House and Fall Creek Retirement Village's credible allegation of compliance. Rawlins House respectfully requests a desk review from the Indiana State Department of Health to confirm the facility has achieved compliance by August 28, 2015. Submission of this plan does not constitute an admission by Rawlins House or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement of admission of the survey allegations.</p>	
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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.

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

PRINTED: 10/02/2015

FORM APPROVED

OMB NO. 0938-0391

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