

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155681	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/27/2013
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NAME OF PROVIDER OR SUPPLIER AUTUMN WOODS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2911 GREEN VALLEY RD NEW ALBANY, IN 47150
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: June 24, 25, 26, and 27, 2013</p> <p>Facility number: 002657 Provider number: 155681 AIM number: 200308930</p> <p>Survey team: Michelle Carter, RN- TC Tammy Alley, RN Bobette Messman, RN Rita Mullen, RN</p> <p>Census bed type: SNF: 47 SNF/NF: 40 Total: 87</p> <p>Census Payor type: Medicare: 29 Medicaid: 23 Other: 35 Total: 87</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on 07/05/2013 by Brenda Nunan, RN.</p>	F000000		
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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.

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F000156 SS=D	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes:</p>						

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	<p>A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits,</p>			

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	<p>and how to receive refunds for previous payments covered by such benefits. Based on record review and interview, the facility failed to ensure Liability and Benefit Coverage End Notices were properly and completely documented to reflect the resident/family was properly notified of the ending of benefit coverage, for 2 of 3 residents reviewed for Medicare Non-Coverage Notices (Resident #28 and #34).</p> <p>Findings include:</p> <p>Medicare benefits non-coverage notices were reviewed on 6/26/13 at 9:30 A.M.</p> <p>Resident #34's notice of Medicare benefit coverage for skilled nursing services ending, dated 4/30/13, indicated Resident #34's Medicare coverage would end on 5/4/13. Handwritten documentation on the notice indicated the following, "4/30/13 MCR (Medicare) meet (meeting) request D/C (discharge) meeting to set date with family for 2 weeks family choice 5/4/13 or 5/5/13, will get back with us." The name of the person contacted was not identified and the form was not signed by a resident representative.</p>	F000156	<p>1. Resident #34 was notified that Medicare was ending by the Social Worker during the discharge meeting. This resident discharged to the hospital of 5/5/13 and did not return. For resident #28, the BOM spoke to his wife although her name was not referenced. 2. Residents that were discharged from Medicare coverage in the last 30 days were reviewed to determine if the Medicare Non-Coverage Letter was provided in accordance with federal requirements for completion.3. The Business Office Manager will continue to initiate the NOMNC when identified during weekly Medicare meeting. The Social Services Director has added to her discharge checklist the process of providing the NOMNC form for tracking to ensure completion. Both employees have been re-educated by the Executive Director on the instructions for accurate completion of the NOMNC.4. The Executive Director or designee will audit for accurate issuance and completion of the NOMNC a minimum of 3 times per week for 1 month then 1 time per week for 2 months.</p>	07/27/2013

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	<p>Resident #28's notice of Medicare benefit coverage for skilled nursing services ending, dated 5/15/13, indicated Resident #28's Medicare coverage would end on 5/18/13. Handwritten documentation on the notice indicated the following, "wife contacted 5/15/13 aware and notified. Will think about staying privately." The name of the person contacted was not identified and the form was not signed by a resident representative.</p> <p>An interview with the Business Office Manager on 6/26/13 at 11:00 a.m., indicated she wrote the notes and had phone conversations with Residents # 28 and 34. Additionally, she indicated times of conversations and who she talked to were not documented.</p> <p>Form Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123, (Approved 12/21/2011), received from the Business Office Manager (BOM) on 6/26/13, indicated the following, "...If the beneficiary/enrollee is not able to comprehend the contents of the notice, it must be delivered to and signed by a representative...If the provider is unable to personally deliver a notice of noncoverage to a</p>				

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	<p>person acting on behalf of a beneficiary/enrollee, then the provider should telephone the representative to advise him or her when the beneficiary's services are no longer covered. The date of the conversation is the date of the receipt of the notice. Confirm the telephone contact by written notice mailed on that same date...Heading...Patient Number: Providers may fill in the beneficiary's unique medical record or other identification number. Signature Line: The beneficiary or the representative must sign this line. Date: The beneficiary or the representative must fill in the date that he or she signs the document...."</p> <p>3.1-4(a)</p>			

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F000246 SS=D	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Based on record review, observation and interview, the facility failed to ensure a resident's shower choices and meal portion choices were met for 1 of 2 residents reviewed for choices (Resident #160).</p> <p>Findings include:</p> <p>Resident #160's clinical record was reviewed on 6/26/13 at 2:00 p.m.</p> <p>Diagnoses included, but were not limited to, ulcerative colitis, arthritis, arterial fibrillation, high blood pressure, hypothyroidism, depression, status post pacemaker placement, urinary retention, gastroesophageal reflux disease (GERD), insomnia, dry eyes, and glaucoma.</p> <p>1. During an observation of Resident #160's room, on 6/24/13 at 3:20 p.m., there was not a shower stool in the shower.</p>	F000246	<p>1. Resident #160's personal preferences were reviewed and are currently followed. A shower chair was provided to remain in her shower for her personal use on 6/26/13. Resident #160 is currently receiving 1/2 portions per her request. 2. All residents personal preferences will be reviewed to ensure followed. 3. All staff were in-serviced by the DHS or designee on the importance of adhering to resident personal preference requests and following them at all times. 4. An audit will be conducted to ensure resident personal preferences are followed to include food and shower preferences. A minimum of 10 residents per week will be checked for 3 months. Results of these audits will be evaluated by the QA committee and audits will continue until 100% compliance is reached for 3 consecutive months.</p>	07/27/2013	

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	<p>During an observation of Resident #160's room, on 6/26/13 at 1:50 p.m., there was not a shower stool in the shower.</p> <p>During an interview with Resident #160, on 6/24/13 at 3:15 p.m., she indicated she did not receive showers per her choice. She indicated, "It seemed like it went a couple months before I got a shower. I need a stool in the shower and I don't have one in my shower. I have to wait until a shower stool is available before I get a shower. Then, the staff must bring a stool/seat to my shower. I don't like waiting on a stool that someone else has used. If I had my own shower stool, I'd probably take more showers."</p> <p>During an interview with the Executive Director (ED) and the Director of Health Services (DHS), on 6/26/13 at 4:20 p.m., they indicated the facility had shower chairs that were shared among residents. Additionally, they indicated they were not aware of the request for a shower chair.</p> <p>During an interview with CNA #9, on 6/26/13 at 3:23 p.m., she indicated Resident #160 did not have a shower chair but the resident had requested one. CNA #9 indicated she did not</p>				

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	<p>know when the request was made.</p> <p>An ADL (Activities of Daily Living) self-care deficit care plan, dated 4/22/13, indicated the following: "Needs assistance or is dependent in personal hygiene, bathing, r/t (related to) weakness." Interventions included: "...provide adaptive/safety equipment."</p> <p>Shower tracking sheets, received from the Assistant Director of Health Services (ADHS), on 6/26/13 at 2:30 p.m., dated 4/10/13 to 6/26/13, indicated Resident #160 received 4 showers in 77 days. Resident #160 was admitted on 4/10/13.</p> <p>An Individual Plan Report, received from LPN #10, at 3:37 p.m., on 6/26/13, indicated Resident #160 would like to have a shower chair.</p> <p>Documentation did not indicate what bathing choices were offered and/or refused. The DHS indicated the resident probably refused, during an interview on 6/26/13 at 4:20 p.m.</p> <p>2. During an interview with Resident #160 on 6/24/13 at 3:15 p.m., she indicated she got too much food on her plate at meals, even though she had requested 1/2 size portions.</p>			

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	<p>An Individual Plan Report, received from LPN, at 3:37 p.m. on 6/26/13, indicated Resident # 160 wants 1/2 portions at meals.</p> <p>An observation was made on 6/26/13 at 5:15 p.m. Resident #160 received a room meal tray for dinner. The plate was full and there were no 1/2 portions. The plate was filled with 3 chicken strips, macaroni and cheese, and peas. Additionally, the tray had side dish of orange slices and a cream cheese pie dessert. Resident #160 indicated this was too much food and overwhelmed her.</p> <p>During an observation and interview on 6/27/13 at 12:06 p.m., Resident #160 received her lunch meal tray in her room. Resident #160 indicated, "this is too much food!" The plate was full with a baked chicken thigh, rice, and stewed tomatoes. Additionally, a chocolate fortified shake and vanilla fortified shake were on the lunch tray. Resident #160 indicated, "I don't know where to start!"</p> <p>An interview with CNA #12, on 6/27/13 at 12:08 p.m., indicated Resident #160 received a full meal portion.</p>			

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview the facility failed to ensure blood pressure and pulses were completed prior to medication administration for 1 of 10 residents reviewed for unnecessary medications in a sample of 10 (Resident # 92).</p> <p>Findings include:</p> <p>The record for Resident # 92 was reviewed on 6/26/13 at 2:50 p.m.</p> <p>Current diagnoses included, but were not limited to, coronary artery disease, hypotension, dementia, atrial fibrillation, and depression.</p> <p>Physician orders for June 2013 indicated an order for Digoxin (antihypertensive) 0.25 milligrams daily and to hold if the pulse was less than 60 and Midodrine HCL (antihypertensive) 5 milligrams daily for hypotension and to hold for a systolic blood pressure greater than 160. Original date of the orders was 4/10/13.</p>	F000282	<p>1. The MD was notified of the lack of documentation of blood pressures and pulses prior to medication administration. No new orders were given. No adverse affects were noted to the resident.2. All residents receiving antihypertensive medications with orders for blood pressure and pulses will be reviewed to determine if additional residents were affected and addressed accordingly.3. All nurses and QMAs will be in-serviced by the DHS or designee regarding the importance of checking blood pressure and pulse prior to administration of antihypertensives if ordered, documenting those results, and following the parameters ordered by the physician.4. An audit will be conducted for a minimum10 residents per week for 3 months. Results of these audits will be evaluated by the QA committee and audits will continue until 100% compliance is reached for 3 consecutive months.</p>	07/27/2013			

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	<p>The Medication Administration Record (MAR) for May 2013 indicated the resident received Midodrine HCL 5 milligrams (mg) on May 6 and 25, 2013, without a documented blood pressure.</p> <p>The April 2013 MAR indicated the resident received Digoxin 0.25 mg on April 17 and 18, 2013, without a documented pulse. The MAR also indicated the resident received Midodrine 5 mg on April 17 and 22, 2013, without a documented blood pressure.</p> <p>Additional information was requested on 6/26/2013 at 3:30 p.m., from LPN #1 regarding the above lacking blood pressure and pulses.</p> <p>On 6/26/13 at 4:30 p.m., the Director of Nursing indicated blood pressures and pulses were not completed and should have been completed.</p> <p>3.1-35(g)(1)</p>			

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F000315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on record review, observation and interview, the facility failed to ensure justification for use of an indwelling anchored catheter and failed to ensure the anchored catheter was positioned in a manner to prevent the possibility of infection for 1 of 2 residents reviewed for anchored catheter in a sample of 2 (Resident # 52).</p> <p>Findings include:</p> <p>The record for Resident # 52 was reviewed on 6/26/13 at 8:08 a.m.</p> <p>Current diagnoses included, but were not limited to, dementia and Methicillin Resistant Staph Aureus of the wound. Diagnoses list was dated 10/31/12.</p> <p>Physician orders for June 2013,</p>	F000315	<p>1. Resident #52's catheter was removed and monitored for elimination.2. All residents with catheters will be reviewed to ensure resident's medical condition justifies the need for a catheter, is discontinued if not warranted, and the justification is documented. in addition, the use of a dignity bag will be confirmed.3. All nursing staff were re-educated by the DHS or designee regarding the use of dignity bags for all catheters, ensuring bags are not placed on the floor, and the resident's medical condition must justify use in accordance with federal regulation. In addition, Division Clinical Support reviewed the federal regulation with the DHS to include justification of use, removal attempts when indicated, and documenting.4. Rounding will be conducted by the DHS or designee to monitor use of dignity bags and appropriate placement for residents with</p>	07/27/2013			

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	<p>indicated an order for an anchored catheter for a wound and to provide anchored catheter every shift and as needed. The original date of the order was 10/31/2012.</p> <p>An admission assessment dated 10/31/2013, indicated the resident was admitted with an anchored catheter for a Stage 3 pressure ulcer.</p> <p>A "Skilled Nursing Assessment and Data Collection Tool" dated 2/1/13, indicated the resident had an anchored catheter.</p> <p>A 3/20/13, "Monthly Nursing Assessment" indicated the resident had an anchored catheter with cloudy amber urine.</p> <p>A 6/12/13, "Monthly Nursing Assessment" indicated the resident had an anchored catheter.</p> <p>A pressure ulcer flow sheet indicated the pressure ulcer on the resident's right buttock was a Stage 2 ulcer since 4/24/13, and on 5/29/13 the ulcer was a 0.5 by 0.5 centimeter ulcer requiring only a treatment of "...Magic Butt q (every) shift/prn (as needed)."</p> <p>The assessments did not indicate a</p>		<p>catheters a minimum of 5 times per week for 1 month and 3 times per week for 2 months. Every resident having a catheter is reviewed during monthly QA for necessity and supporting documentation. Results of these audits will be evaluated by the QA committee and audits will continue until 100% compliance is reached for 3 consecutive months.</p>				

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	<p>justification for use or that an attempt to remove the anchored catheter had been completed.</p> <p>A lab dated 4/5/13 indicated the resident had Pseudomonas Aeruginose and Escherichia Coli in her urine, indicating a urinary tract infection.</p> <p>A physician order for 4/6/13, indicated an order for Levaquin 500 milligrams (antibiotic) daily for pending urine culture.</p> <p>A physician order dated 6/18/13 indicated an order for a urinalysis due to confusion.</p> <p>A urinalysis dated 6/19/2013 indicated the resident had bacteria in her urine. The lab result was reported to the physician and an antibiotic was ordered.</p> <p>A physician order dated 6/21/13 indicated an order for Cipro 250 milligrams (antibiotic) by mouth twice a day for 7 days for a urinary tract infection.</p> <p>A nursing note dated 6/25/13 indicated the resident complained of bladder spasms and the physician was notified.</p>			

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	<p>During an observation on 6/26/13 at 8:15 a.m., the resident was sitting in her recliner. Her anchored catheter urinary drainage bag was positioned with the bottom of the bag laying on the floor. No dignity bag or cover was observed.</p> <p>During an observation on 6/26/13 at 8:25 a.m., with LPN # 2, she indicated the catheter bag should be in the dignity bag and not on floor.</p> <p>During an interview with CNA # 3 on 6/26/13 at 8:27 a.m., she indicated she had not placed the catheter in the dignity bag when she got the resident up into her recliner. She indicated the drainage bag should not be positioned on the floor.</p> <p>Additional information was requested from LPN # 4 on 6/26/13 at 1:43 p.m., regarding the justification for the continued use of the resident's anchored catheter or if there been any attempt to remove the anchored catheter since the admission date of 10/31/12.</p> <p>During interview on 6/26/13 at 1:55 p.m., LPN # 4 indicated the resident had a Stage 3 pressure ulcer that is now presenting as a Stage 2 and the</p>			

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	<p>anchored catheter would remain in for protection of the ulcer site. She indicated there had not been an attempt to remove the anchored catheter since the admission date.</p> <p>3.1-41(a)(1)</p>				

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F000323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review, observation and interview, the facility failed to ensure a bed alarm was functioning to prevent the possibility of an accident for 1 of 3 residents reviewed for accidents in a sample of 3 (Resident # 58).</p> <p>Findings include:</p> <p>During an observation, on 6/26/13 at 4:57 p.m., the resident's roommate was heard telling resident #58 not to get up. Upon entering the room, Resident # 58 was standing at the side of her bed, near the foot, and the bed alarm was not sounding. The call light was turned on and LPN # 2 entered the room and assisted the resident back into the bed. At that time during interview, LPN # 2 indicated the bed alarm cord was not hooked up to the bed alarm and the bed alarm was not sounding.</p> <p>The record for resident # 58 was reviewed on 6/27/13 at 9:42 a.m.</p>	F000323	<p>1. Resident #58 continues to be at risk for falls and has an order for a chair alarm which is in place and functioning. The alarm box was replaced on 6/27/13. 2. All residents with orders for an alarm will be checked to ensure the alarm is in place and functioning. 3. The nursing staff was re-inserviced by the DHS or designee on the use of alarms and their proper function to include ensuring the alarm is activated correctly when checking on residents. A designated supply box with fall intervention supplies, to include alarms, as been implemented to provide employees with one easy location to obtain alarms when needed. 4. Rounding will be conducted by the DHS or designee to check for proper alarm placement and function for a minimum of 5 residents 5 times per week for 1 month and 3 times per week for 2 months. Results of these audits will be evaluated by the QA committee and audits will continue until 100% compliance is reached for 3 consecutive months.</p>	07/27/2013	

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	<p>Current diagnoses included, but were not limited to, weakness, spinal stenosis, dementia, hypertension, and depression.</p> <p>A plan of care, dated 6/7/13, indicated the resident was at risk for falls. Approaches included, but were not limited to, bed and chair alarms. This approach was added to the careplan on 6/12/13.</p> <p>A nursing note, dated 4/25/13, indicated the resident was found on the floor and sent to the emergency room and returned. The resident reported she became dizzy prior to the fall.</p> <p>On 6/27/13 at 12:30 p.m., the Director of Nursing indicated the bed alarm had been replaced due to the cord would not stay in the alarm box.</p> <p>A 3/08, policy titled "Falls Management Program Guidelines" was provided by the Director of Nursing on 6/27/13 at 1:58 p.m., and deemed as current. The policy indicated: "Purpose: "...strives to maintain a hazard free environment, mitigate fall risk factors and implement preventative measures...Procedure:...b. Care plan interventions should be implemented</p>						

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	<p>that address the resident's risk factors...."</p> <p>3.1-45(a)(2)</p>			

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F000325 SS=G	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on record review and interview, the facility failed to prevent weight loss for a resident identified at risk for weight loss and had ordered interventions to prevent weight loss for 1 of 3 residents reviewed for nutrition in a sample of 3 (Resident # 58). Resident # 58 lost greater than 5% of her body weight in one week and 8.9% in 30 days.</p> <p>Findings include:</p> <p>The record for resident # 58 was reviewed on 6/27/13 at 9:42 a.m.</p> <p>Current diagnoses included, but were not limited to, weakness, spinal stenosis, dementia, hypertension, and depression.</p> <p>A nutrition plan of care, dated 5/13/13, indicated the resident had significant weight change.</p>	F000325	<p>1. Resident #58 is currently receiving fortified shakes as ordered. Her weight has now improved to 103 lbs as of 7/14/13.2. All residents with orders for fortified shakes or nutritional supplements will be reviewed to ensure being given as ordered and documented appropriately.3. All nursing staff will be in-serviced by the DHS or designee regarding the current process for taking off orders to include transcribing to the MAR. In addition, the current chart check system will be reviewed with 3rd shift to ensure the double-check system to confirm order are taken off correctly is in place. 4. Audits will be conducted by the DHS or designee of residents with orders for fortified shakes/nutritional supplements to ensure receiving and documenting. This will occur for 10 residents per week for one month and 5 residents per week for 2 months. Results of these audits will be evaluated by the QA</p>	07/27/2013			

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	<p>Approaches included, but were not limited to, fortified shakes three times daily, Med Pass (supplement) 60 milliliters four times daily.</p> <p>The resident's weight record for May 2013 indicated the following weights:</p> <p>May 4: 96.6 May 12: 94.2 May 18: 88.8 May 27: 88.4</p> <p>A weight change notification, dated 5/18/13, indicated a weight loss of 5.6 pounds since 5/12/13. Resident # 58 lost greater than 5% of her body weight in one week and 8.9% in 30 days.</p> <p>A Nutrition Assessment, dated 5/13/13, indicated the resident was readmitted to the facility on 5/2/13, after a hospital stay for possible stroke. The assessment indicated the resident's weight was 96.6 pounds on 5/4/12. An addendum to the assessment, dated 5/13/13, indicated the resident was to receive fortified shakes twice daily between meals.</p> <p>A Nutrition Assessment, dated 6/3/13, indicated the resident weighed 88.4 pounds on 5/27/13. The note indicated this was a significant weight</p>		committee and audits will continue until 100% compliance is reached for 3 consecutive months.				

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	<p>loss of 8.9 % in 30 days. The resident continued to have a decreased appetite. The note indicated the resident was to continue on fortified shakes twice daily between meals and recommended to increase the shake to three times per day.</p> <p>The note indicated the resident drank the shakes well.</p> <p>A physician's order, dated 5/11/13, indicated an order for health shakes, twice daily, between meals.</p> <p>A physician's order, dated 6/3/13, indicated an order for fortified shakes to be increased from twice daily to three times daily, between meals.</p> <p>Physician's orders, dated 6/13/13, indicated an order for fortified shakes, between meals, three times daily.</p> <p>The May 2013 Medication Administration Record (MAR) did not have the health shakes listed or documented as given.</p> <p>Additional information regarding the administration of health shakes for the month of May was requested from the Director of Nursing on 6/27/13 at 11:25 a.m.</p>			

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	<p>On 6/27/13 at 12:24 p.m., the Assistant Director of Nursing indicated she could not locate any information indicating the resident received her health shakes as ordered in May 2013. She indicated there was a physician order on 5/11/13 but the nurse had not transcribed the order onto the MAR.</p> <p>A policy dated 12/07, titled "...High Risk Nutrition" was provided by the DON on 6/27/13 at 2:30 p.m., and deemed as current. The policy indicated: "Program Overview: The intent of this program is to assure the resident maintains acceptable parameters of nutritional status, taking into account the resident's clinical condition or other appropriate interventions when there is a nutritional problem...Purpose: To establish an affective nutrition program that will provide interventions for those residents with established criteria defining them as being high nutritional risk...High Nutritional Risk Criteria...Significant weight loss: 5% in 30 days...."</p> <p>3.1-46(a)(1)</p>				

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F000328 SS=D	<p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on record review, observation and interview, the facility failed to ensure a Midline intravenous site dressing was changed as ordered by the physician for 1 of 1 resident observed for Midline dressing change in a sample of 1 (Resident # 58).</p> <p>Findings include:</p> <p>The record for resident # 58 was reviewed on 6/27/13 at 9:42 a.m.</p> <p>Current diagnoses included, but were not limited to, weakness, spinal stenosis, dementia, hypertension, and depression.</p> <p>A physician order, dated 6/12/13, indicated an order for a Midline intravenous catheter and to change the Midline dressing every 7 days and as needed.</p>	F000328	<p>1. Resident #58 no longer has a Midline IV site dressing. LPN #11 was re-educated on the proper procedure of documenting a treatment, specifically documenting when completed and not prior to providing.2. All residents with IV sites requiring a dressing change will be reviewed to ensure changed as ordered.3. All nurses will be re-inserviced by the DHS or designee to follow physician orders for dressing changes and the proper procedure for this to include documentation. 4. The DHS or designee will audit 5 residents per week requiring an IV site dressing change to ensure completed as ordered and documented per policy. Results of these audits will be evaluated by the QA committee and audits will continue until 100% compliance is reached for 3 consecutive months.</p>	07/27/2013			

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	<p>A nursing note, dated 6/12/13, indicated the resident had a Midline catheter placed by (name of company).</p> <p>During an observation on 6/26/13 at 11:00 a.m., RN # 8 administered an intravenous medication to Resident # 58. RN # 8 indicated she could not identify the written date on the Midline dressing. She indicated she would get the dressing changed since the date was not clear.</p> <p>During an observation on 6/26/13 at 5 p.m., with LPN # 2, the Midline dressing was observed and the date was verified as June 12, 2013.</p> <p>During an interview with LPN # 11 on 6/26/13 at 5:05 p.m., she indicated the Medication Administration Record had initials in the box for the Midline dressing change dated for June 19, 2013. No other date of dressing change was verified on the MAR. She indicated the dressing change was due to be changed on that date.</p> <p>During an interview with the Director of Nursing on 6/27/13 at 10:45 a.m., she indicated the nurse who had signed the dressing change on June 19 stated he remembered the event and the resident had declined to have</p>						

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	<p>the dressing changed at that time. The Director of Nursing indicated she could not verify if anyone had attempted to change the Midline dressing after June 19, until the scheduled change on June 26, 2013.</p> <p>A 1/24/2011 policy titled "...Midline Catheter Maintenance" was provided by the Director of Nursing on 6/27/13 at 2:30 p.m., and deemed as current. The policy indicated: "...The midline catheter is changed 24 hours after insertion then one time per week and as needed...."</p> <p>3.1-47(a)(2)</p>			

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F000329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>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 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 ensure non-medication interventions were implemented prior to giving a PRN (as needed) anti-anxiety medication and failed to ensure medication effectiveness was assessed and documented, for 1 of 10 residents reviewed for unnecessary medications, in a sample of 10 (Resident #56).</p> <p>Findings include:</p>	F000329	<p>1. Resident #56 continues to have Xanax PRN order for anxiety. 2. All residents with physician orders for PRN medications will be reviewed to determine if non-medication interventions are being implemented and effectiveness assessed and documented. 3. All nurses and QMAs will be re-educated by the DHS or designee on the proper procedure for assessment prior to giving a PRN medication, assessing effectiveness and documenting both. The current system of</p>	07/27/2013			

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	<p>The clinical record review for Resident # 56, was completed on 6/26/13 at 3:00 p.m.</p> <p>Diagnoses for Resident #56 included, but were not limited to, type 2 diabetes, obesity, atrial fibrillation, physiologic tremors, high blood pressure, urinary retention, coronary artery disease (CAD), anxiety, and depression.</p> <p>A physician's order, dated 1/4/13, indicated Xanax (anti-anxiety) 0.5 mg (milligrams) tablet, give 1 tablet, orally, every 6 hours, as needed for anxiety.</p> <p>Xanax 0.5 mg. was administered on 6/6/13 at 4:00 p.m., as indicated on the PRN medication tracking form for June 2013. The indicated reason for administration was anxiety. Interventions for the anxiety episode were not indicated.</p> <p>Xanax 0.5 mg. was administered on 6/7/13 at 6:00 p.m., as indicated on the PRN medication tracking form for June 2013. The indicated reason for administration was anxiety. Interventions for the anxiety episode were not indicated. Effectiveness of the medication was not indicated,</p>		<p>documenting the administration and assessment of PRNs on the PRN Tracking form, filed next to the MAR, will be reviewed with the nursing team to ensure this form is utilized.4. The DHS or designee will audit 5 residents receiving PRN medication 5 times per week for 1 month then 5 residents per week for 2 months. Results of these audits will be evaluated by the QA committee and audits will continue until 100% compliance is reached for 3 consecutive months.</p>				

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	<p>either.</p> <p>A care plan, titled Psychotropic drug use, updated 5/28/13, indicated the following:</p> <p>The use of psychotropic drug places resident at risk for drug-related: hypotension, gait disturbance, cognitive impairment, and other generalized discomforts, behavioral impairments, ADL (activities of daily living) decline, decline in appetite, and abnormal involuntary movements.</p> <p>Drug: anti-anxiety/anti-depressant.</p> <p>Interventions:</p> <ol style="list-style-type: none"> 1. Monitor for s/s (signs and symptoms) of drug related: (if noted, report to nurse) hypotension, gait disturbance, cognitive impairment, behavioral impairment, ADL decline, decline in appetite. 2. Report to MD any negative outcomes associated with use of drug. 3. Administer med (medication) as prescribed. 4. Educate resident/family on potential risks/benefits of psychotropic drug use. 5. Monitor for effectiveness of 				

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	<p>psychotropic drug(s).</p> <p>6. Work with physician/pharmacy to provide lowest therapeutic dose.</p> <p>During an interview with LPN #10, on 6/26/13 at 3:15 p.m., she indicated interventions and effectiveness for Xanax should be identified on the the PRN medication form, in the proper box. She indicated the entry should have had interventions and effectiveness documented on all entries and all entries were not completed.</p> <p>3.1-48(a)(3) 3.1-48(a)(4)</p>			

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F000371 SS=E	<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 Based on observation and interview, the facility failed to maintain the temperature of the milk, being served during lunch, prior to serving the residents. This affected 3 of 3 serving areas outside of the main dining room.</p> <p>Findings include:</p> <p>During an observation on the Cherry Hill unit, on 6/26/13 at 11:10 a.m., a cart with quart size carafes of milk, tea and lemonade was taken from the main kitchen and left in the hallway. The carafes were sitting in a container of ice.</p> <p>During a temperature check with the Director of Food Services (DFS), on 6/26/13 at 11:40 a.m., the carafes of milk, left sitting in the Cherry Hill unit hallway, measured as follows:</p> <p>Chocolate milk was 43.0 degrees Fahrenheit</p>	F000371	<p>1 & 2. The milk that was identified to be above the required serving temperature was discarded and not served. The milk cooler was serviced by a qualified technician to improve the cooling ability on 6/27/13.3. The following systems will be reviewed with the Dining Services team by the DFS to ensure execution: a) checking food and drink temperatures prior to service to include checking milk temperatures with each meal b) delivery of beverage carts to each unit no sooner than 15 minutes prior to meal service, c) ensuring the Lexan used to hold the cold beverages is filled full of ice to maintain the cold temperature and d) the facility policy for cold beverage temperatures.4. The DFS or designee will audit milk temperatures at point of service 10 times per week for 3 months. Results of these audits will be evaluated by the QA committee and audits will continue until 100% compliance is reached for 3 consecutive months.</p>	07/27/2013			

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	<p>White milk was 46.7 degrees Fahrenheit</p> <p>During a temperature check with the DFS on the Legacy Lane unit, on 6/26/13 at 11:55 a.m., the carafes of milk temperatures measured as follows:</p> <p>Chocolate milk was 43.6 degrees Fahrenheit</p> <p>White milk was 44.6 degrees Fahrenheit</p> <p>During a temperature check with the DFS on the Harvest Place unit, on 6/26/13 at 12:15 p.m., the carafes of milk temperatures were as follows:</p> <p>Chocolate milk was 39.9 degrees Fahrenheit</p> <p>White milk was 42.0 degrees Fahrenheit</p> <p>During an interview with the DFS, on 6/26/13 at 12:20 p.m., he indicated the milk should be held at a lower temperature.</p> <p>A Hot & Cold Temperature Holding Guideline, received from Campus Support #5, on 6/27/13 at 4:10 p.m., indicated the following:</p>			

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	<p>"Guideline: The temperatures of all foods on the serving line will be measured prior to resident service and recorded at every meal.</p> <p>Procedure: ...</p> <p>3. Cold foods should be 40 degrees or less when the temperature is taken in the Kitchen at the time of service...."</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p>			

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F000441 SS=D	<p>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.</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, record review, and interview, the facility failed to</p>	F000441	1,2,3. All staff will be re-educated on facility infection control	07/27/2013			

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	<p>insure infection control practices were followed in a manner to prevent the potential for the spread of infections for 1 of 3 dining rooms observed for hand washing (activities associate #6), and for 1 of 5 nursing staff observed for equipment handling during medication pass (RN #8).</p> <p>Findings include:</p> <p>1. During the observation of Legacy lunch dining on 6/24/2013, at 11:25 a.m., activities associate # 6, distributed opened silverware to dining room tables after direct resident contact and did not wash her hands. Activities associate #6, was observed to hand hold and shake hands with residents and then continue to distribute opened silverware to dining room tables.</p> <p>During an interview with the Activity Director (AD) on 6/27/13 at 9:50 a.m., she indicated staff were instructed to wash their hands if direct contact with a resident occurs, before and during resident dining.</p> <p>2. During an observation with RN #8, 6/26/13 at 11:15 a.m., RN # 8 completed a medication pass where she used a stethoscope to check the</p>		<p>procedures to include handwashing and disinfecting equipment. In addition, multiple locations of handwashing facilities and alcohol dispensers will be identified and reviewed with employees to reiterate available access. 4. The DHS or designee will round daily to observe a minimum of 10 instances oper week for 3 months to execute good infection control procedures to include handwashing and disinfecting equipment. Results of these audits will be evaluated by the QA committee and audits will continue until 100% compliance is reached for 3 consecutive months.</p>				

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	<p>residents gastrostomy tube for placement. She placed the stethoscope on the bed. When she exited the room, she picked up the stethoscope, placed it on the medication book on the medication cart, then moved it to the narcotic book. At that time during interview, she indicated she should have sanitized the stethoscope before she placed it on the medication cart.</p> <p>A policy titled "Guidelines for Handwashing", provided by the Administrator on 6/27/2013, at 2:30 p.m., indicated that staff will wash hands before/after having direct physical contact with residents.</p> <p>3.1-18(l) 3.1-18(b)(1)</p>			

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F000465 SS=E	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview the facility failed to maintain water temperatures at appropriate levels for 3 of 10 rooms observed for water temperatures (Room #'s 112, 113, and 110) and failed to maintain the physical environment in good repair for 14 of 40 resident rooms observed (Room #'s 505, 406, 105, 100, 402, 425, 421, 408, 503, 301, 318, 112, 108, and 110).</p> <p>Findings include:</p> <p>1. During the environmental tour with the Director of Physical Plant Operations (DPPO), on 6/27/13 at 9:45 a.m., the following resident room water temperatures were found:</p> <p>Room 112 bathroom water temperature was 90 degrees Fahrenheit.</p> <p>Room 113 bathroom water temperature was 90 degrees Fahrenheit.</p> <p>Room 110 bathroom water temperature was 98.6 degrees</p>	F000465	<p>1. The low water temperatures were addressed and fixed by a contractor on 6/27/13. Doors, walls, and equipment identified in disrepair will be fixed. 2. An audit of all resident rooms will be conducted and repair work initiated if needed. 3. The DPO was re-educatd by the ED on the policy for resident room water temperatures, the procedure for monitoring and the need to correct immediately if concerns. All staff were re-educated by the ED or designee regarding the importance of rooms, furniture, and equipment maintained in good repair and utilizing facility Work Order process. A new system will be implemented that requires all Environmental Services Associates to track any necessary repairs on an individual tracking form for each room to be maintained in a binder and reviewed by the DPO routinely. Work orders will still be utilized for repairs requiring more immediate attention.4. Then Environmental Services Director will audit 3 rooms from each unit daily to determine if any repair needed. She will then cross-check this with the existing audit form being utilized by the Environmental Services</p>	07/27/2013

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	<p>Fahrenheit.</p> <p>During an interview with the DPPO, on 6/27/13 at 10:30 a.m., he indicated the water temperatures on the east end of the 100 hallway are too low and need to be adjusted.</p> <p>A "Hot Water Temperatures" guide received from Campus Support #5, on 6/27/13 at 4:20 p.m., indicated the following:</p> <p>"...2. Water temperatures at point of use must be maintained between 100 degrees Fahrenheit and 120 degrees Fahrenheit."</p> <p>2. During the environmental tour with the DPPO, on 6/27/13 at 9:45 a.m., the following resident rooms were found to need repairs:</p> <p>Room 505: the south wall had gouged areas in the plaster that had been painted over and not repaired/filled-in prior to painting.</p> <p>Room 406: the room door is marred and scratched.</p> <p>Room 105: the bathroom door was marred and scratched.</p> <p>Room 100: the room door had</p>				Associate and address accordingly. This process will be on-going and will only be changed if recommended and approved by the QA Committee.		

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	<p>gouges and scratches.</p> <p>3. During resident room observations on 6/24/13 between 3:07 p.m.- 4:08 p.m., and on 6/25/13 between 9 a.m.- 10 p.m., the following was observed:</p> <p>Room 402 The cove board to the left of the closet door was pulling away from the wall. There was marring on the wall above the corner cove board to the right side of the closet door.</p> <p>The wall to the left of the shower had an area of marring approximately 2 inches above the cove board approximately 8 inches in width.</p> <p>Room 425 The wall to the left of the bathroom door had an area of scuffed paint approximately 3 centimeters by 2 centimeters. The entry to the shower in the bathroom had a marred lining.</p> <p>Room 421 The over-the-bed light did not light up when the string was pulled.</p> <p>Room 408 The wall to the right side of the shower had marring on the corner approximately 5 inches up the wall. There was marring in the corner of</p>			
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	<p>the wall approximately 8 inches up the wall.</p> <p>Room 503 The corner wall to the left of the bathroom door had loose cove board and marring above the cove board.</p> <p>4. During an observation on 06/25/2013, at 10:01 a.m. , of resident room 301A , the bathroom door had deep grove marring, the bathroom sink needed repair, and the plaster and painting at the back of the sink in bathroom was flaking and peeling.</p> <p>During an observation on 06/25/2013, at 10:11 a.m., of resident room 318A, there was marring on the walls above the bathroom door and on the bathroom walls.</p> <p>During an observation on 06/25/2013, at 11:25 a.m., of resident room 100B, the furniture (dresser and chairs) needed repair and there was marring on the walls and the bathroom doors.</p> <p>During an observation on 06/25/2013, at 11:05 a.m., of resident room 112B, there were marred walls throughout the room and the bathroom had a quarter size hole in the shower area.</p>				

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	<p>During an observation on 06/24/2013, at 2:58 p.m., of resident room 108A, the bathroom glove box was broken, the plastic projections on walls needed removed, the bathroom baseboard needed repair, and the over the commode chair had front legs that needed repair.</p> <p>During an observation on 06/24/2013, at 3:22 p.m., of resident room 110B, the bathroom glove box was broken, the shower call light socket was loose from the wall, the archway and the door to the bathroom had marring, chipping and peeling.</p> <p>During an interview with the DPPO, on 6/27/13 at 10:30 a.m., he indicated the walls and doors needed some attention. Housekeeping and nursing were suppose to put in work orders when they saw areas that need repaired.</p> <p>3.1-19 (f)</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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: 155681	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/27/2013
NAME OF PROVIDER OR SUPPLIER AUTUMN WOODS HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 2911 GREEN VALLEY RD NEW ALBANY, IN 47150		
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