STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155608	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 04/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WITTENBERG LUTHERAN VILLAGE	1200 E LUTHER DR CROWN POINT, IN 46307

(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
K010000		K010000		

A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).

Survey Date: 04/28/14

Facility Number: 000515
Provider Number: 155608
AIM Number: 100290820

Surveyor: Bridget Brown, Life Safety Code Specialist

At this Life Safety Code survey, Wittenberg Lutheran Village was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.

The original one story building with a partial basement identified as building 01 was determined to be to be of Type II (000) construction and was fully sprinklered. The Chapel/Fellowship Hall identified as building 02 was determined to be Type V (000) construction and occupies a 1990 wing addition to the facility. The facility is surveyed as two buildings due to different construction types.

The facility has a fire alarm system with hard wired smoke detection in the corridors and in spaces open to the corridors. Resident

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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 A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED
	155608		04/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WITTENBERG LUTHERAN VILLAGE	1200 E LUTHER DR CROWN POINT, IN 46307

(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
	rooms are equipped with battery powered smoke detectors. The facility has a capacity of 155 and had a census of 143 at the time of this survey. All areas of resident access are sprinklered. A detached grounds maintenance shed was unsprinklered. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K010022 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4 Based on observation and interview, the facility failed to ensure 1 of 2 doors in the assisted dining room likely to be mistaken for a way of exit was identified as "No Exit." LSC 7.10.8.1 requires any door that is neither an exit nor a way of exit access and is located or arranged so it is likely to be mistaken for an exit shall be identified by a sign that reads: NO exit. This deficient practice affects visitors, staff and 10 or more residents on the 600 hall. Findings include: Based on observation with the Facilities Maintenance Director on 04/28/14 at 12:55 p.m., two doors located on opposite sides of the assisted dining room led to two different corridors which could be seen through the glass panels in the upper halves of each door. The door leading to the 700 hall was locked and required a key to unlock the door.	K010022	**K - 022** 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were affected by this alleged deficient practice. 2. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** Residents using the 600 hall memory support dining and activity room have the potential to be affected by this alleged deficient practice. A temporary sign was immediately placed on the door on 4/28/14. A permanent sign to correct this alleged deficiency was installed on 4/30/14. **3. What measures will be put into place or what**	04/30/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155608	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED 04/28/2014
NAME OF PROVIDER OR SUPPLIER WITTENBERG LUTHERAN VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 E LUTHER DR CROWN POINT, IN 46307	

(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
	The key was carried by maintenance staff. The Facilities Maintenance Director said at the time of observation, the door was kept locked because the dining room was part of a locked unit. The 700 hall was not part of the locked unit and the facility did not want residents entering the 700 hall. The Facilities Maintenance Director acknowledged at the time of observation, the door to the 700 hall could be mistaken for a means of exit. 3.1-19(b)		**systemic changes will be made to ensure that the deficient practice does not recur.** Staff to monitor that the sign is intact through daily rounds on the unit. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes will be completed.** Safety Officer and Safety Committee to monitor for compliance through reviewing at the monthly QI meeting for 6 months.	
K010069 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on record review and interview, the facility failed to ensure 1 of 1 range hood fire extinguishing systems was inspected and approved every 6 months by properly trained and qualified persons. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 8-2.1 requires the inspection and servicing of the fire extinguishing system and listed exhaust hoods containing a constant or fire actuated water system shall be made at least every 6 months by properly trained and qualified persons. Furthermore, NFPA 96, 8-2.1.1 requires actuation components, including remote manual pull stations, mechanical or electrical devices, detectors, actuators, fire actuated dampers, etc., shall be checked for proper operation during the inspection in accordance with the manufacturer's listed	K010069	**K - 069** 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were affected by this alleged deficient practice. 2. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** Residents in the healthcare pavilion have the potential to be affected by this alleged deficient practice. There was a new inspection / cleaning schedule facilitated with our vendor, Reid's. Fire Protection, to ensure that there would be no possibility of	05/09/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED
	155608		04/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WITTENBERG LUTHERAN VILLAGE	1200 E LUTHER DR CROWN POINT, IN 46307

(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
	procedures. This deficient practice could affect visitors, staff and 10 or more residents in the adjacent dining areas. Findings include: Based on a review of contracted commercial hood extinguishing system inspection records with the Facilities Maintenance Director 04/28/14 at 3:00 p.m., inspection and service records for the commercial range hood fire equipment extinguishing systems for the main kitchen were dated 07/18/13 and 03/17/14, an eight month lapse between inspections required at least every six months. The Facilities Maintenance Director said at the time of record review, he did not know why the inspections had exceeded the six months allowed. An email from the Facilities Maintenance Director dated 04/29/14 explained the hood systems contractor's failed effort to clean the duct exhaust in January 2014 was due to "their equipment freezing" resulting in a postponement. The freezing of equipment could not explain their failure to inspect the commercial hood extinguishing system. 3.1-19(b)		equipment freezing due to severe winter weather conditions and that these inspections to stay within the regulatory six month interval required based on October / April inspections **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** A new cleaning / inspection schedule was established with our vendor, Reid's Fire Protection, to ensure that there would be no possibility of equipment freezing due to severe winter weather conditions and that these inspections to stay within the regulatory six month interval based on October / April inspections **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes will be completed.** Safety Officer and Safety Committee to monitor for compliance by reporting to the monthly QI meeting for 6 months.	
K010147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure 2 of 2 flexible cords were not used as a substitute for fixed wiring.	K010147	**K - 147** 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the**	04/28/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155608	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 04/28/2014
NAME OF PROVIDER OR SUPPLIER WITTENBERG LUTHERAN VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 E LUTHER DR CROWN POINT, IN 46307	

(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
K020000	NFPA 70 National Electrical Code, 1999 Edition, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect visitors, staff, and 15 or more residents on the 100 hall. Findings include: Based on observation during a tour of the facility with the Facilities Maintenance Director on 04/28/14 at 11:40 a.m., a power strip extension cord was piggybacked and used to supply power to equipment in the gift shop. The Facilities Maintenance Director said at the time of observation, the power strips should not have been used in this manner. 3.1-19(b)		**deficient practice?** No residents were affected by this alleged deficient practice. 2. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** Residents on 100 hall have the potential to be affected by this alleged deficient practice. The additional power strip was removed from its piggy back position and re-located to another wall outlet on 04/28/14. Gift shop manager was in serviced on 04/28/14 on the proper and regulatory use of power strips in the gift shop area. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** The gift shop area was added to the daily maintenance resident room audit to ensure that this occurrence does not happen again. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes will be completed.** Safety Officer and Safety Committee to monitor for compliance by reviewing audit from above in the monthly QI meeting for 6 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155608	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING	X3) DATE SURVEY COMPLETED 04/28/2014
NAME OF PROVIDER OR SUPPLIER WITTENBERG LUTHERAN VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 E LUTHER DR CROWN POINT, IN 46307	

(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
		K020000		
	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 04/28/14 Facility Number: 000515 Provider Number: 155608 AIM Number: 100290820 Surveyor: Bridget Brown, Life Safety Code Specialist At this Life Safety Code survey, Wittenberg Lutheran Village was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. The original one story building with a partial basement identified as building 01 was determined to be to be of Type II (000) construction and was fully sprinklered. The Chapel/Fellowship Hall identified as building 02 was determined to be Type V (000) construction and occupies a 1990 wing addition to the facility. The facility is surveyed as two buildings due to different construction types. The facility has a fire alarm system with hard wired smoke detection in the corridors and in spaces open to the corridors. Resident rooms are equipped with battery powered smoke detectors. The facility has a capacity			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING	X3) DATE SURVEY COMPLETED
	155608		04/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WITTENBERG LUTHERAN VILLAGE	1200 E LUTHER DR CROWN POINT, IN 46307

(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
	of 155 and had a census of 143 at the time of this survey. All areas of resident access are sprinklered. A detached grounds maintenance shed was unsprinklered. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K020021 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 Based on observation and interview, the facility failed to ensure 1 of 1 door sets in the fire barrier wall separating the health care Fellowship Hall from the independent living occupancy was held open only by a device which would allow it to close upon activation of the fire alarm system. This deficient practice could affect visitors, staff and 10 or more residents who could use the Fellowship Hall. Findings include:	K020021	**K - 021** 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were affected by this alleged deficient practice.2. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** Residents using the Fellowship Hall area have the potential to be affected by this	04/28/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155608	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING	X3) DATE SURVEY COMPLETED 04/28/2014
NAME OF PROVIDER OR SUPPLIER WITTENBERG LUTHERAN VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 E LUTHER DR CROWN POINT, IN 46307	

(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
	Based on observation with the Facilities Maintenance Director on 04/28/14 at 1:45 p.m., there was a double door set in the fire wall separating the Fellowship Hall corridor from the independent Living occupancy. The door set was equipped with a door coordinator which, if the door did not close in the correct sequence, failed to work. If the door with the astragal closed first, the second door closed against the astragal on the first door and the door could not close and latch. The Facilities Director acknowledged at the time of observation, the door coordinator failed to work to allow the doors to close in the right sequence. 3.1-19(b)		alleged deficient practice. The door coordinator identified in this k-tag was immediately adjusted on 04/28/14 to allow for proper closing. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** A daily audit will be conducted by maintenance staff to ensure that this alleged deficient practice does not occur again. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes will be completed.** Safety Officer and Safety Committee to monitor for compliance through review of the daily audit during our monthly QI meeting. The audits will be reviewed for 6 months or until 100% compliance is achieved.	
K020069 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on record review and interview, the facility failed to ensure 1 of 1 range hood fire extinguishing systems was inspected and approved every 6 months by properly trained and qualified persons. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 8-2.1 requires the inspection and servicing of the fire extinguishing system and listed exhaust	K020069	**K - 069** 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were affected by this alleged deficient practice. 2. **How other residents having the potential to be affected by the same deficient practice will be**	05/09/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155608	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING	X3) DATE SURVEY COMPLETED 04/28/2014
NAME OF PROVIDER OR SUPPLIER WITTENBERG LUTHERAN VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 E LUTHER DR CROWN POINT, IN 46307	

(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
	hoods containing a constant or fire-actuated water system shall be made at least every 6 months by properly trained and qualified persons. Furthermore, NFPA 96, 8-2.1.1 requires actuation components, including remote manual pull stations, mechanical or electrical devices, detectors, actuators, fire actuated dampers, etc., shall be checked for proper operation during the inspection in accordance with the manufacturer's listed procedures. This deficient practice could affect visitors, staff and 10 or more residents in the adjacent dining areas. Findings include: Based on a review of contracted commercial hood extinguishing system inspection records with the Facilities Maintenance Director 04/28/14 at 3:00 p.m., inspection and service records for the commercial range hood fire equipment extinguishing systems for the the Fellowship Hall kitchen were dated 07/18/13 and 03/17/14, an eight month lapse between inspections required at least every six months. The Facilities Maintenance Director said at the time of record review, he did not know why the inspections had exceeded the six months allowed. An email from the Facilities Maintenance Director dated 04/29/14 explained the hood systems contractor's failed effort to clean the duct exhaust in January 2014 was due to "their equipment freezing" resulting in a postponement. The freezing of equipment could not explain their failure to inspect the commercial hood extinguishing system. 3.1-19(b)		**identified and what corrective action(s) will be taken.** Residents in the healthcare pavilion have the potential to be affected by this alleged deficient practice. There was a new inspection / cleaning schedule facilitated with our vendor, Reid's. Fire Protection, to ensure that there would be no possibility of equipment freezing due to severe winter weather conditions and that these inspections to stay within the regulatory six month interval required based on October / April inspections **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** A new cleaning / inspection schedule was established with our vendor, Reid's Fire Protection, to ensure that there would be no possibility of equipment freezing due to severe winter weather conditions and that these inspections to stay within the regulatory six month interval based on October / April inspections **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes will be completed.** Safety Officer and Safety Committee to monitor for compliance by reporting to the monthly QI meeting for 6 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155608	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING	X3) DATE SURVEY COMPLETED 04/28/2014
NAME OF PROVIDER OR SUPPLIER WITTENBERG LUTHERAN VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 E LUTHER DR CROWN POINT, IN 46307	

(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