

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155385	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/13/2013
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NAME OF PROVIDER OR SUPPLIER CAMELOT CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1555 COMMERCE ST LOGANSPORT, IN 46947
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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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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: November 4, 5, 7, 8, 12, and 13, 2013</p> <p>Facility number: 000466 Provider number: 155385 AIM number: 100289810</p> <p>Survey team: Rita Mullen, RN, TC Sandra Nolder, RN (November 4 and 5, 2013) Michelle Carter, RN (November 5, 7, 8, 12 and 13, 2013) Bobette Messman, RN (November 12 and 13, 2013) Maria Pantaleo, RN (November 12 and 13, 2013)</p> <p>Census bed type: NF: 54 SNF/NF: 5 Total: 59</p> <p>Census payor type: Medicaid: 59 Total: 59</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2.</p>	F000000	<p>Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correctionis prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance.</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.

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	Quality Review was completed by Tammy Alley RN on November 14, 2013.			

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F000458 SS=E	<p>483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms.</p> <p>Based on record review, observation and interview, the facility failed to provide at least 80 square feet (sq ft) per resident in multiple resident rooms. This was evidenced in 4 of 25 resident rooms in the facility. (Rooms 1, 16, 18 and 19)</p> <p>Findings include:</p> <p>During the initial facility observation, on 11/4/13 at 10:00 a.m., Rooms #1 and 16 were found to have three beds. Rooms #18 and 19 were found to have four beds.</p> <p>Facility documentation of room size certification, dated 8/16/2011, and provided by the Administrator on 11/4/13 at 11:00 a.m., indicated the following:</p> <ol style="list-style-type: none"> 1. Room #1 3 beds/NF 238.8 Sq Ft/79.6 Sq Ft for each resident. 2. Room #16 3 beds/NF 237.9 Sq Ft/79.3 Sq Ft for each resident. 3. Room #18 4 beds/NF 319.6 Sq 	F000458	A new request for waiver was submitted on 11/21/2013 to the Indiana State Department of Health for a Room-Size Waiver for Title 19 NF room #'s 1, 16, 18, and 19.	11/30/2013	

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	<p>Ft/79.9 Sq Ft for each resident.</p> <p>4. Room #19 4 beds/NF 319.6 SqFt/79.9 Sq Ft for each resident.</p> <p>During an interview with the facility Administrator, on 11/4/13 at 11:15 a.m., she indicated a room size waiver has been requested in the past and granted.</p> <p>3.1-19(1)(2)</p>				