

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155488	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/07/2016
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NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-ROLLING HILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 3625 ST JOSEPH RD NEW ALBANY, IN 47150
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F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: June 1, 2, 3, 6, and 7</p> <p>Facility number: 000526 Provider number: 155488 AIM number: 100266970</p> <p>Census bed type: SNF/NF: 88 Total: 88</p> <p>Census payor type: Medicare: 5 Medicaid: 66 Other: 17 Total: 88</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 34233 on June 16, 2016.</p>	F 0000	<p>This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Attached you will find the completed Plan of Correction and attachments for annual survey dated June 7, 2016. We respectfully request that our plan of correction, be considered for a paper compliance desk review. Should you have any questions, please feel free to contact me at (812) 948-0670. Sincerely, John Keaton, Executive Director</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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F 0250 SS=D Bldg. 00	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on record review, observation and interview, the facility failed to provide medically-related social services to maintain the highest practical mental and psychosocial well-being to a newly-admitted resident on the Reflections Unit assessed as a wanderer to determine pattern/reasoning for wandering. This deficient practice affected 1 of 3 residents reviewed for accidents. (Resident #3)</p> <p>Findings include:</p> <p>Review of the clinical record for Resident #3 on 6/3/16 at 1:30 p.m., indicated the resident had diagnosis which included, but was not limited to: dementia with behavioral disturbance.</p> <p>The Admission Minimum Data Set (MDS) assessment dated 5/20/16, indicated the resident wandered daily which placed him at significant risk of getting to a potentially dangerous place, but did not significantly intrude on the privacy of activities of others.</p>	F 0250	<p><b>1. Immediate intervention:</b> Resident identified had no adverse reaction to deficient practice. A. Wander evaluation was completed on resident identified. B. Care plan was updated to reflect current wandering status of resident identified. C. Wander patient profile/elopement book was updated to reflect current status of resident identified.</p> <p><b>2. Others at risk:</b> No other residents were identified at risk related to deficient practice. A. 100% wandering assessments completed on all residents. (Reference A) B. Care plans validated/updated to reflect current wandering status. C. Wandering patient profiles/ elopement book updated to reflect current status. (Reference A)</p> <p><b>3. Education:</b> A. Staff educated on the definition of unsafe wandering. B. Facility staff educated on wandering assessment, care plans and elopement book. C. Direct caregivers educated on elopement book. D. Elopement drills will be</p>	06/30/2016
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	<p>The 14 day MDS assessment dated 5/25/16, indicated the resident had wandered daily.</p> <p>During an observation on 6/1/16 at 12:30 p.m., Resident #3 was sitting in his wheelchair at the dining table eating his lunch.</p> <p>During an observation on 6/3/16 at 1:00 p.m., Resident #3 was asleep in his bed.</p> <p>During an observation on 6/6/16 between 11:20 a.m. and 12:10 p.m., Resident #3 was sitting at the dining table in his wheelchair looking around waiting for his lunch tray.</p> <p>In an interview with the Unit Manager LPN #1 on 6/3/16 at 1:10 p.m., she indicated "Resident is not a wander risk, we encourage him to be involved in activities and he may want to go lay down as he tires easily. If residents leave the activity, someone will re-direct or go with them. Resident #3 moves slowly in his w/c (wheelchair) heel to toe moving it, he does not let anyone really help him as he'll tell them he's got it."</p> <p>On 6/3/16 at 1:45 p.m., the Reflections Program Coordinator presented a copy of the behavior logs for May and June 2016. Review of these logs included continuous</p>		<p><b>conducted PRN. 4. Ongoing audits: A. Initial mood and Bx audit will be initiated on all new admits and SSD will follow up as needed. This practice will occur 5 days a week times 4 weeks, then 3 times a week times 4 weeks then will continue PRN with new admits as an ongoing practice of facility. (Reference A)B. Audit new admits to ensure care plan, profile and elopement book are initiated and accurate. This practice will occur 5 days a week times 4 weeks, then 3 times a week times 4 weeks then will continue PRN with new admits as an ongoing practice of facility. (Reference A)</b></p>				

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	<p>motion, i.e. pacing, intrusive wandering, elopement attempts, as behaviors being monitored. A one time episode of wandering was entered on day shift the day the resident was admitted to the facility on 5/13/16. All other days and shifts recorded the resident as not having exhibited any wandering behaviors.</p> <p>Review of the Interdisciplinary Team progress notes between 5/13/16 and 6/6/16 indicated no documentation of the resident experiencing wandering behaviors.</p> <p>On 6/6/16 at 11:20 a.m., RN #1 indicated "(Resident #3) is a sight see-er - just likes to be where the action is. He strolls in his w/c but it is not at risk for wandering or trying to get out of the unit or intrude on others. He just likes to wheel to where he can watch things going on around him. There is a purpose to what he is doing."</p> <p>On 6/7/16 at 9:40 a.m., the Reflections Program Coordinator presented a new copy of the Wander/Elopement Risk assessment. She indicated "I corrected it to reflect the fact he is on the secured unit and because of this, he would automatically be considered being at risk for wandering and is care planned for being on the secured unit."</p>			

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	<p>In an interview with the Reflections Program Coordinator on 6/7/16 at 9:50 a.m., she indicated "As the Social Worker on the Dementia unit, I coded the MDS as the resident being a wander risk because I observe him wandering daily. I coded it based on my observations. It doesn't mean he is an elopement risk, just a wanderer. He moves around if he gets bored, or leaves the activity. I did not document what I saw so it's not on the behavior logs or in my notes."</p> <p>Review of the 5/15/16 care plan indicated "Resident is here for long term placement on the Reflections unit r/t (related to) Dementia". The goal was "To meet [Name of Resident] long term needs." With the approach to "Provide a secure unit". The Care plan did not address the specific approaches or interventions to meet the psychosocial needs which required the resident to be on the secured unit.</p> <p>On 6/7/16 at 11:00 a.m., the Director of Nursing from a sister facility presented a copy of the Social Worker's Job Description as the Reflections Program Coordinator. Review of this Job Description at this time included, but was not limited to:"...Essential Functions:...As part of the Interdisciplinary team, develops</p>			

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F 0279 SS=D Bldg. 00	<p>approaches/interventions to meet the psychosocial needs of the residents..."</p> <p>3.1-34(a)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to develop a care plan which addressed goals and approaches for a resident assessed as being at risk for wandering. This deficient practice affected 1 of 19 residents reviewed for care plans. (Resident #3)</p>	F 0279	<p><b>1. Immediate intervention:</b> <b>Resident identified had no adverse reaction to deficient practice. A. Wander evaluation was completed on resident identified. B. Careplan was updated to reflect current wandering status of resident</b></p>	06/30/2016

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	<p>Findings include:</p> <p>Review of the clinical record for Resident #3 on 6/3/16 at 1:30 p.m., indicated the resident had diagnosis which included, but was not limited to: dementia with behavioral disturbance.</p> <p>The Admission Minimum Data Set (MDS) assessment dated 5/20/16, indicated the resident wandered daily which placed him at significant risk of getting to a potentially dangerous place, but did not significantly intrude on the privacy of activities of others.</p> <p>The 14 day MDS assessment dated 5/25/16, indicated the resident had wandered daily.</p> <p>Review of the 5/15/16 care plan indicated "Resident is here for long term placement on the Reflections unit r/t (related to) Dementia" The goal was "To meet [Name of Resident] long term needs." The care plan had an approach of "Provide a secure unit". No other approaches or interventions were found.</p> <p>During an interview on 6/7/16 at 9:40 a.m., the Reflections Program Coordinator presented a new copy of the Wander /Elopement Risk assessment.</p>		<p><b>identified. C. Wander patient profile/elopement book was updated to reflect current status of resident identified.</b></p> <p><b>2. Others at risk: No other residents were identified at risk related to deficient practice.</b></p> <p><b>A. 100% wandering assessments completed on all residents. (Reference A) B. Care plans validated/updated to reflect current wandering status. C. Wandering patient profiles/ elopement book updated to reflect current status. (Reference A)</b></p> <p><b>3. Education: A. Staff educated on the definition of unsafe wandering. B. Facility staff educated on wandering assessment, care plans and elopement book. C. Direct caregivers educated on elopement book. D. Elopement drills will be conducted PRN. 4. Ongoing audits: A. Initial mood and Bx audit will be initiated on all new admits and SSD will follow up as needed. This practice will occur 5 days a week times 4 weeks, then 3 times a week times 4 weeks then will continue PRN with new admits asan ongoing practice of facility. (Reference A) B. Audit new admits to ensure care plan, profile and elopement book are initiated and accurate . This practice</b></p>		

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F 0371 SS=D Bldg. 00	<p>She indicated "I corrected it to reflect the fact he is on the secured unit and because of this, he would automatically be considered being at risk for wandering and is care planned for being on the secured unit."</p> <p>3.1-35(a) 3.1-35(b)(1) 3.1-35(b)(2)</p> <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, record review and interview, the facility failed to ensure infection control practices and standards were maintained related to food and drink service to 3 of 14 residents observed in the Reflections Unit Dining Room. (Residents # 31, 55, and 6)</p> <p>Findings include:  During the lunch observation in the Reflections Unit Dining Room on 6/01/16 from 11:34 a.m. to 11:48 a.m.,</p>	F 0371	<p><b>will occur 5 days a week times 4 weeks, then 3 times a week times 4 weeks then will continue PRN with new admits as an ongoing practice of facility. (Reference A)</b></p> <p>1. Resident #42 was assessed on 6/22/16 and found to have no signs or symptoms of a newly acquired infectious process. Resident # 42, #31, #55, #8, and #6 unable to identify. Direct care staff performing dining room duties completed education on hand washing followed by competency check-off observed by SDC/Designee. (Reference B) 2. All residents eating in the dining room have potential to be affected. Facility infection control surveillance and infection screenings have found no</p>	06/30/2016			

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	<p>13 residents were observed. CNA # 2 applied the clothing protector with both hands for Resident # 42, fastening it at the neck, and straightening it on the front of the resident's clothing. CNA # 2 then obtained cups for Resident # 31, and Resident # 55. She placed the cups in front of the residents and touched Resident # 55's arm, without handwashing or applying hand sanitizer between resident contacts.</p> <p>During the lunch observation in the Reflections Unit Dining Room on 06/06/16 from 11:46 a.m. to 12:00 p.m., 14 residents were observed. CNA # 1 was holding both of Resident # 8's hands, leading the resident to a chair with both of her hands. The CNA then went over to the drawer and obtained a trash bag and placed soiled clothing protectors into the bag. CNA # 1 then assisted Resident # 6 to the dining table by wheelchair, without handwashing or using hand sanitizer between residents and after contact with soiled linens.</p> <p>During an interview on 06/07/16 at 2:30 p.m., the DON (Director of Nursing) indicated the staff should wash their hands after any resident contact.</p> <p>On 06/03/16 at 8:45 a.m., the DON provided a copy of the Hand</p>		<p>residents to be presenting with signs or symptoms of newly acquired infectious processes related to these causal factors.</p> <p>3. Staff Development Coordinator/ designee will in-service nursing staff on handwashing and dining services by June 30, 2016. Nursing staff will complete competency check-offs on handwashing and dining services by June 30, 2016. (Reference B)</p> <p>4. The Director of Nursing or designee will observe handwashing and dining services 5 times a week for 30 days, then 3 times a week for 30 days, then twice weekly for 30 days all findings will be addressed immediately for correction. Competency observation results will be reviewed in monthly PI meeting x3 months then the PI committee will determine if 100% compliance has been achieved and the need for ongoing monitoring. (Reference B)</p>	

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	<p>Hygiene/Handwashing policy which indicated, but was not limited to, the following: "Handwashing is the single most important procedure for preventing the spread of infection...Hand hygiene is to be performed: Before and during food preparation; as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks;...After handling soiled equipment or utensils;...After touching bare body parts of the body other than clean hands and clean, exposed portions of arms...After contact with a patient's intact skin...Alcohol-Based Hand Rub...8...a. Decontaminate hands before having direct contact with patients/patients[duplicate] d. Decontaminate hands after contact with a patient's/patient's [duplicate] intact skin..."</p> <p>On 06/07/16 at 2:42 p.m., the Dietary Manager provided a copy of the Dining Standards which indicated, but was not limited to, the following: "Safety/Infection Control/Sanitation...40. Staff completes hand hygiene according to procedure at the beginning of meal service and as needed throughout the meal service..."</p> <p>3.1-21(i)(2)</p>			

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F 0441 SS=D Bldg. 00	<p>3.1-21(i)(3)</p> <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.</p>			
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	<p>(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. Based on observation, interview and record review, the facility failed to ensure proper infection control practices and standards were maintained related to incontinence care for 2 of 4 residents observed. (Residents #42 and 5)</p> <p>Findings include:</p> <p>During an observation on 06/06/16 at 10:25 a.m., CNA # 1 and Activities Assistant # 1 were performing incontinence care for Resident # 42. After handwashing and applying gloves, Activities Assistant # 1, filled the tub with warm water. The hair/body soap was poured into the water. The washcloth was wettened and CNA # 1 began washing the labial area of Resident # 42, CNA # 1 folded the washcloth after two swipes in the labial area, and wiping the creases to each side. Without rinsing the skin, a dry towel was obtained and the labial area was dried by the CNA pulling the cloth in a downward motion, then upward with the same area of the towel. CNA # 1 removed her gloves and</p>	F 0441	<p>1. Resident #42 and #5 were assessed on 6/22/16 and found to have no signs or symptoms of a newly acquired infectious process. Certified Nursing Assistants performing incontinence care completed 1:1 education on infection control with incontinence care, followed by competency check-off observed by SDC/Designee. (Reference C)</p> <p>2. All incontinent residents have potential to be affected. Facility infection control surveillance and infection screenings have found no residents to be presenting with signs or symptoms of newly acquired infectious processes related to these causal factors.</p> <p>3. Staff Development Coordinator/ designee will in-service nursing staff on infection control and incontinence care by June 30, 2016. Nursing staff will complete competency check-offs on handwashing and incontinence care by June 30, 2016. (Reference C)</p> <p>4. The Director of Nursing or</p>	06/30/2016

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NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-ROLLING HILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 3625 ST JOSEPH RD NEW ALBANY, IN 47150
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	<p>performed handwashing, then applied clean gloves. The resident was rolled to the left side and the anal area was washed with a wet/soapy washcloth, swiping twice with the same area of the washcloth in a front to back motion. Without rinsing the skin, a dry towel was obtained and the anal area was dried with a back to front motion performed twice with the same area of the cloth.</p> <p>During an observation on 06/07/16 at 9:34 a.m., CNA # 3 and CNA # 1 were performing incontinence care for Resident # 5. CNA # 3 and CNA # 1 performed handwashing and applied gloves. CNA # 1 filled a basen with water and poured a No rinse soap into the water then wettened a washcloth. CNA # 3 washed the labial area first, using back and forth motion with the same area of the washcloth. Then a towel was obtained to dry the labial area, using back and forth motion. The resident was rolled to the right side. A clean washcloth was wettened in the no rinse soapy water, and using the same area of the washcloth, with a back and forth motion, the buttocks and the anus were cleaned. A towel was obtain and the buttocks and anus were dried with the same area of the towel.</p> <p>During an interview on 06/07/16 at 12:17</p>		<p>designeewill observe incontinence care using appropriatecompetency check-off 5 times a week for 30 days, then 3 times a week for 30days, then twice weekly for 30 days all findings will be addressed immediatlyfor correction. Competency observation results will be reviewed in monthly PI meetingx3 months then the PI committee will determine if 100% compliance has been achievedand the need for ongoing monitoring. (Reference C)</p>	

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	<p>p.m., the DON indicated during incontinence care, the staff should wash the resident from front to back. They should wash, fold the washcloth with each swipe, but clean with different portions of the washcloth. Staff should obtain a clean washcloth for the different body areas. When the staff wash the resident with soap, they should rinse the soap off of the resident before drying.</p> <p>On 06/03/16 at 8:45 a.m., the DON provided a copy of the Incontinence Management policy which indicated, but was not limited to, the following: "Procedure...8. Clean the perineal area frequently with an appropriate skin cleanser; a no-rinse skin cleanser with a pH range similar to that of normal skin is preferred over soap and water for the prevention of incontinence associated dermatitis."</p> <p>3.1-18(a)</p>			

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F 0465 SS=D Bldg. 00	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE 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 ensure bedroom doors to the hallway closed and latched securely when pulled closed. This deficient practice affected 4 of 24 resident rooms observed. (Rooms #410, 404, 411, and 412).</p> <p>Findings included:</p> <p>During room observations on 6/2/16 between 9:05 a.m. and 1:30 p.m., the following was observed:</p> <p>1. Rooms # 410, 404, 411 and 412 - when the doors to the hallway were pulled shut, the edge banged on the frame preventing the door from closing securely and latching. The doors required a person to have to slam the door hard in order for it to shut.</p> <p>Interview with Resident #97 on 6/2/16 at 9:25 a.m., indicated sometimes the door would not shut at all and would swing back open. She indicated this had been an issue for awhile.</p> <p>Interview with Resident #49 on 6/3/16 at 9:15 a.m., indicated the door never did</p>	F 0465	<p>1. Resident bedroom doors to the hallway for room #410, 404, 411, and 412 repaired and made to close and latch securely when pulled closed on 6/4/16.</p> <p>2. All residents had the potential to be affected. A 100% audit completed on facility doors to ensure when doors to the hallway are pulled closed they close and latch securely on 6/3/16.</p> <p>3. Staff education regarding not slamming resident room doors as well as how to complete a work order to facilitate repair of resident room door to close securely and latch completed by 6/30/16.</p> <p>4. Facility maintenance director or designee to audit resident room doors to hallway to ensure they close and latch securely when pulled closed; 5 times a week for 30 days, then 3 times a week for 30 days, then twice weekly for 30 days, then weekly as an ongoing process of this facility all findings will be addressed immediately for correction. Audit results will be reviewed in monthly PI meeting x3 months then the PI committee will determine if 100% compliance has been achieved and the need for ongoing monitoring. (Reference D)</p>	06/30/2016			

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	<p>shut tight which was why he usually told staff to just leave it open. He also indicated it disturbed him, especially at night when staff had to slam his and several other residents' room doors in order for them to close all the way.</p> <p>A re-check of the resident rooms at 11:00 a.m. on 6/3/16, indicated the doors remained an issue in that pulling and shutting the doors hard (slamming) was required to shut the door tightly. Room 411 and 404's doors would not shut tight and swung back open.</p> <p>In an interview with the Maintenance Director on 6/7/16 at 10:00 a.m., he indicated "I did come in this past weekend and found 5 doors on the 400 hall which were not shutting properly and staff did have to slam them, especially Resident #49's. If residents or staff bump the door handle going into the room, it will cause the door mechanism to lock and prevents the door from closing - just hits the door frame. If you turn the handle inside the door, it will release it and the door will close properly. I know it is a safety and fire hazard if the door does not close properly like it should but am unsure what else to do. I do check the doors monthly to be sure they are in working order because I know they are an issue. Last done around first of May but</p>			

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

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	did not have to replace or repair any doors. In April I did."  3.1-19(f)				