

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155605 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 08/02/2013 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER GRANDVIEW HEALTH & REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 1959 E COLUMBUS ST MARTINSVILLE, IN 46151 |
|--|---|

| (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 |
|--------------------|---|---------------|--|----------------------|
| F000000 | <p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00132642.</p> <p>Complaint IN00132642 - Unsubstantiated due to lack of evidence.</p> <p>Survey dates: July 29, 30, 31, August 01, and 02, 2013.</p> <p>Facility number: 000400 Provider number: 155605 AIM number: 100266880</p> <p>Survey team: Susan Worsham, RN-TC Diana McDonald, RN Melissa Gillis, RN Denise Schwandner, RN</p> <p>Census bed type: SNF: 06 SNF/NF: 52 Total: 58</p> <p>Census payor type: Medicare: 7 Medicaid: 42 Private: 9 Total: 58</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 correction is prepared and submitted as a requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance.</p> <p>Please find enclosed the plan of correction for the survey ending August 2, 2013. Due to the low scope and severity of the survey finding, please also find enclosed sufficient documentation providing evidence of compliance with the plan of correction.</p> <p>The documentation serves to confirm the facility's allegation of compliance. Should additional information be necessary to confirm compliance, feel free to contact me.</p> <p>Respectfully,</p> | |

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.

| | | | | | |
|--|--|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155605 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 08/02/2013 |
| NAME OF PROVIDER OR SUPPLIER GRANDVIEW HEALTH & REHABILITATION CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1959 E COLUMBUS ST MARTINSVILLE, IN 46151 | | |
| (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 | |
| | <p>Grandview Health & Rehabilitation was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the Recertification and State Licensure Survey.</p> <p>Quality review completed on August 08, 2013; by Kimberly Perigo, RN.</p> | | <p>Jan Ledlow Administrator</p> | | |