

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155789	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/27/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RIDGEWOOD HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 181 CAMPUS DR LAWRENCEBURG, IN 47025
---	--

(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</p> <p>Survey dates: June 18, 19, 20, 24, 25, 26, 27, 2013</p> <p>Facility number: 012523 Provider number: 155789 AIM number: 201027870</p> <p>Survey team: Gordon Tyree, RN, TC Diana Sidell, RN Joan Laux, RN</p> <p>Census Bed Type: SNF/NF: 67 Residential: 49 Total: 116</p> <p>Census by Payor Type: Medicare: 28 Medicaid: 25 Other: 63 Total: 116</p> <p>Residential Sample: 7</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 7/08/13 by Suzanne</p>	F000000	<p>This plan of correction is prepared and executed because it is required by the provision of the State and Federal law and not because RidgeWood Health Campus agrees with the allegations and citations. RidgeWood Health Campus maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. This plan of correction shall also operate as the facility's written credible allegation of compliance.</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: 155789	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/27/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RIDGEWOOD HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 181 CAMPUS DR LAWRENCEBURG, IN 47025
---	--

(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
	Williams, RN			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155789	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/27/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RIDGEWOOD HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 181 CAMPUS DR LAWRENCEBURG, IN 47025
---	--

(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
F000279 SS=D	<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 ensure 1 of 3 residents reviewed for care planning related to urinary catheter use of 26 residents reviewed for care planning, had a care plan developed for catheter use. (Resident #146)</p> <p>Findings include:</p> <p>Resident #146's record was reviewed on 6/27/13 at 10:24 a.m. The record indicated Resident #146 was admitted with diagnoses that included, but were not limited to,</p>	F000279	Resident #146's record was immediately clarified to reflect appropriate catheter size and balloon size. Resident #146's care plan was immediately updated to reflect catheter use. DHS/Designee will inservice nursing staff regarding need for size of catheter and balloon size on physician's orders and the necessity of a care plan addressing catheter use for those residents using a catheter by 8-13-13. DHS/Designee will audit residents with catheters upon admission and during monthly change over for adequate physician orders addressing size	08/14/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155789	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/27/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RIDGEWOOD HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 181 CAMPUS DR LAWRENCEBURG, IN 47025
---	--

(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>Alzheimer's, anxiety, urinary retention, urinary tract infection, depression, dementia, and history of ovarian cancer.</p> <p>A Medication Administration Record (MAR), dated 3/19/13, indicated: "Foley cath in place for urinary retention [check] for patency", with 10-6, 6-2, and 2-10 (shifts) listed beside the order.</p> <p>Physician's recapitulation orders dated 6/1/13 through 6/30/13, indicated: "Foley cath in place for urinary retention: check for potency (sic) every shift and prn (as needed)." This order was dated 3/20/13.</p> <p>A physician's telephone order dated 6/20/13 indicated: "FC (Foley catheter) clarification ____ Fr (French) [with] _____ cc (cubic centimeters) balloon. FC cath care [every] shift and PRN for soiling. May [change] PRN for dislodgement or occlusion." The Foley catheter size and the size of the balloon was not written on the order.</p> <p>Review of the resident's care plans indicated the use of the urinary catheter was not addressed.</p> <p>During an interview, on 6/27/13 at 4:53 p.m., the Director of Health</p>		<p>of catheter and balloon size and ensure catheter use is properly care planned weekly x 4 and monthly until 100% compliance is reached for 3 consecutive months. The results of the audit will be presented to the Quality Assurance Committee to be reviewed and for recommendations until compliance is reached for 3 consecutive months. The need for ongoing audits will be determined by the QA committee.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155789	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/27/2013
NAME OF PROVIDER OR SUPPLIER RIDGEWOOD HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 181 CAMPUS DR LAWRENCEBURG, IN 47025		
(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>Services (DHS) indicated the catheter size was 16FR with a 30 cc bulb, because Resident #146 has been a long term resident and that is the size she has had.</p> <p>During an interview, on 6/27/13 at 5:23 p.m., the DHS indicated they didn't have the cath size or the bulb size for the resident's catheter, and the resident didn't have the size listed when she was admitted from the assisted living side. The DHS also indicated they didn't have a care plan specifically for the use of the Foley catheter.</p> <p>On 6/27/13, at 5:56 p.m., the Minimum Data Set Assessment Coordinator indicated their facility policy for Foley catheters didn't address the catheter size, or bulb size.</p> <p>3.1-35(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155789	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/27/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RIDGEWOOD HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 181 CAMPUS DR LAWRENCEBURG, IN 47025
---	--

(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
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 1 of 3 residents who met the criteria for urinary catheters had complete physician's orders which were followed for the urinary catheter, of 26 residents reviewed for physician's orders. (Resident #146)</p> <p>Findings include:</p> <p>Resident #146's record was reviewed on 6/27/13 at 10:24 a.m. The record indicated Resident #146 was admitted with diagnoses that included, but were not limited to, Alzheimer's, anxiety, urinary retention, urinary tract infection, depression, dementia, and history of ovarian cancer.</p> <p>A Medication Administration Record (MAR), dated 3/19/13, indicated: "Foley cath in place for urinary retention [check] for patency", with 10-6, 6-2, and 2-10 (shifts) listed beside the order.</p> <p>Physician's recapitulation orders</p>	F000282	<p>Resident #146's record was immediately clarified to reflect appropriate catheter size and balloon size. Resident #146's care plan was immediately updated to reflect catheter use. DHS/Designee will inservice nursing staff regarding need for size of catheter and balloon size on physician's orders and the necessity of a care plan addressing catheter use for those residents using a catheter on 8-13-13. DHS/Designee will audit residents with catheters upon admission and during monthly change over for adequate physician orders addressing size of catheter and balloon size and ensure catheter use is properly care planned weekly x 4 and monthly until 100% compliance is reached for 3 consecutive months. The results of the audit will be presented to the Quality Assurance Committee to be reviewed and for recommendations until compliance is reached for 3 consecutive months. The need for ongoing audits will be determined by the QA committee.</p>	08/14/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155789	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/27/2013
NAME OF PROVIDER OR SUPPLIER RIDGEWOOD HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 181 CAMPUS DR LAWRENCEBURG, IN 47025		
(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>dated 6/1/13 through 6/30/13 indicated: "Foley cath in place for urinary retention: check for potency (sic) every shift and prn (as needed)." This order was dated 3/20/13.</p> <p>A physician's telephone order dated 6/20/13 indicated: "FC (Foley catheter) clarification ____ Fr (French) [with] _____cc (cubic centimeters) balloon. FC cath care [every] shift and PRN for soiling. May [change] PRN for dislodgement or occlusion." The Foley catheter size and the size of the balloon was not written on the order.</p> <p>During an interview, on 6/27/13 at 4:53 p.m., the Director of Health Services (DHS) indicated the catheter size was 16FR with a 30 cc bulb because Resident #146 has been a long term resident and that is the size she has had.</p> <p>During an interview, on 6/27/13 at 5:23 p.m., the DHS indicated they didn't have the cath size or the bulb size for the resident's catheter, and the resident didn't have the size listed when she was admitted from the assisted living side.</p> <p>On 6/27/13, at 5:56 p.m., the Minimum Data Set Assessment</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155789	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/27/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RIDGEWOOD HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 181 CAMPUS DR LAWRENCEBURG, IN 47025
---	--

(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
R000000	<p>Coordinator indicated their facility policy for Foley catheters didn't address the catheter size, or bulb size.</p> <p>3.1-35(g)(2)</p> <p>The following state residential finding is cited in accordance with 410 IAC 16.2-5.</p>	R000000	<p>This plan of correction is prepared and executed because it is required by the provision of the State and Federal law and not because RidgeWood Health Campus agrees with the allegations and citations. RidgeWood Health Campus maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. This plan of correction shall also operate as the facility's written credible allegation of compliance.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155789		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/27/2013	
NAME OF PROVIDER OR SUPPLIER RIDGEWOOD HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 181 CAMPUS DR LAWRENCEBURG, IN 47025			
(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			
R000117	<p>410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure that one staff with current first aide training was scheduled for each shift in that 13 shifts out of 42 shifts, over a 2 week period, had no first aide trained staff scheduled. This deficient practice had the potential to affect all 50 residents currently residing in the residential units.</p> <p>Findings include:</p>	R000117	The Nursing Leadership team was immediately inserviced regarding scheduling at least one first aid certified staff member on Assisted Living each shift. by the DHS/DHS/Designee will inservice staff scheduled on Assisted Living regarding requirement to have at least one staff member first aid certified work on each shift by 8-13-13. DHS/Designee will require first aid certification be completed by at least one staff member per	08/14/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155789		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/27/2013	
NAME OF PROVIDER OR SUPPLIER RIDGEWOOD HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 181 CAMPUS DR LAWRENCEBURG, IN 47025			
(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>On 6/27/13 at 3:30 p.m., the "Nursing staff daily schedule" was reviewed for staff coverage with cardiopulmonary resuscitation (CPR) and first aide training. The "Nursing staff daily schedule" indicated the following shifts did not have required first aide-trained staff coverage:</p> <ul style="list-style-type: none"> -6/14/13 on the first and second shift. -6/15/13 on the first and second shift. -6/16/13 on the first and second shift. -6/17/13 on the first and third shift. -6/18/13 on the first shift. -6/20/13 on the second shift. -6/22/13 on the first shift. -6/23/13 on the first shift. -6/24/13 on the second shift. <p>During an interview, on 6/27/13 at 3:18 p.m., the Assistant Director of Health Services indicated that they had a total of four employees with first aide training. She also indicated they (the facility) have a training module in their system, and that they were going to be making the first aide training mandatory, soon.</p> <p>During an interview, on 6/27/13 at 4:05 p.m., the Director of Health Services indicated that she was not aware until today that they only had four employees with certified first aide</p>		<p>shift assigned to Assisted Living. First aid certification is now available and mandatory for at least one nursing staff member assigned to Assisted Living through eMerge, our online learning portal. DHS/Designee will audit staffing schedules on Assisted Living weekly x4 and monthly thereafter to ensure at least one nursing staff member scheduled is first aid certified until 100% compliance is reached for 3 consecutive months. The results of the audits will be presented to the Quality Assurance Committee to be reviewed for recommendations until 100% compliance is reached for 3 consecutive months. The need for ongoing audits will be determined by the QA committee.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155789	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/27/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RIDGEWOOD HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 181 CAMPUS DR LAWRENCEBURG, IN 47025
---	--

(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>training. The Director of Health Services also indicated she had taken her position a short time ago, had never worked for an assisted living facility, and was not aware of the requirement of having a certified first aide employee on each shift. She indicated: "This is not listed as a mandatory class. We (the facility) are going to make this class mandatory for every employee now."</p> <p>On 6/27/13, at 4:40 p.m., a review of the "Staff Training Guidelines" indicated:</p> <p>"Purpose: To ensure the staff caring for residents has the necessary training and knowledge to meet the needs of the residents."</p> <p>"Procedure: 1. Prior to working independently staff shall receive orientation and training which shall include but may not be limited to...j. First aid-either a Red Cross class or training by a licensed registered nurse or successful completion of eMerge online learning course for all staff in applicable states."</p> <p>"2. Documentation of training shall be maintained in the employee file and include: a. The time, date and location of the training. b. Name and title of the instructor. c. Name of the participants...e. Acknowledgement of attendance by written signature."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155789	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/27/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RIDGEWOOD HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 181 CAMPUS DR LAWRENCEBURG, IN 47025
---	--

(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