

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155566	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/17/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WARSAW MEADOWS CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 300 E PRAIRIE ST WARSAW, IN46580
--	--

(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
F0000	<p>This visit was for the Investigation of Complaint IN00099867.</p> <p>Complaint IN00099867-Substantiated. Federal/state deficiencies related to the allegation are cited at F309.</p> <p>Survey Dates: November 16 and 17, 2011</p> <p>Facility number: 000359 Provider number: 155566 AIM number: 100274920</p> <p>Survey Team: Diane Nilson, RN</p> <p>Census bed type: SNF/NF: 65 Total: 65</p> <p>Census payor type: Medicare: 12 Medicaid: 46 Other: 7 Total: 65</p> <p>Sample: 3</p> <p>This deficiency also reflects state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 11/22/11 by Suzanne Williams, RN</p>	F0000		

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:  155566	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/17/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WARSAW MEADOWS CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 300 E PRAIRIE ST WARSAW, IN46580
--	--

(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
F0156 SS=G	<p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155566	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/17/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WARSAW MEADOWS CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 300 E PRAIRIE ST WARSAW, IN46580
--	--

(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>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155566	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/17/2011
NAME OF PROVIDER OR SUPPLIER  WARSAW MEADOWS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 E PRAIRIE ST WARSAW, IN46580		
(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>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>Based on record review and interview, the facility failed to assure 1 resident (Resident A) of 3 residents reviewed for code status in a sample of 3, was provided Cardiopulmonary Resuscitation (CPR) according to the resident's advance directive.</p> <p>Findings include:</p> <p>1. The Director of Nursing Services (DNS), was interviewed, at 10:45 a.m., on 11/16/11, and indicated an incident occurred on 11/13/11 regarding Resident A. She indicated Resident A had been declining, and RN #1 had called the Nurse Practitioner, who left orders not to send the resident to the hospital, that the resident was in the process of dying and to leave the resident at the nursing home for "Comfort measures." The DNS indicated the resident was later found cold with mottled skin and RN#1 did not do CPR (Cardiopulmonary resuscitation) because</p>	F0156	<p><b>This plan of correction is to serve as Warsaw Meadows Care Center's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Warsaw Meadows Care Center or it's management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. The following corrective action was implemented immediately following this self-reported incident. We respectfully request paper review. F156 483.10(b)(5) – (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</b> It is the practice of Warsaw Meadows Care Center to inform the resident both orally and in writing</p>	11/29/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155566		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/17/2011	
NAME OF PROVIDER OR SUPPLIER  WARSAW MEADOWS CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 300 E PRAIRIE ST WARSAW, IN46580			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>the nurse thought comfort measures only meant no CPR. The DNS indicated the resident was listed as a full code.</p> <p>Review of the closed record for Resident A, beginning at 1:15 p.m., on 11/16/11, indicated diagnoses including, but not limited to, mental retardation, coronary artery disease, depression, chronic obstructive pulmonary disease, dementia with behaviors, and cerebral vascular accident.</p> <p>A nurse's note, dated 11/13/11 at 7:30 a.m., indicated, "Res (resident) unresponsive to verbal stimuli T (temperature) 97.2 P (pulse) 125 R(respirations) 24 O2 (oxygen) sats (saturation) 86%, O2 2/L (liters), resident placed back to bed c (with) 2 assist, HOB(head of bed) (arrow pointing up), B/P (blood pressure) 50/palp(palpable). Skin pale, cool/dry. Unable to take any meds(medications.)</p> <p>The next nursing note, dated 11/13/11 at 9:15 a.m., indicated the Nurse Practitioner "wants resident kept comfortable." The oxygen saturation level was 97%, respirations were 24, and blood pressure 100/60. The resident's color had improved slightly and the resident was "not so ashen et (and) pale." The nurse's note further indicated the resident remained on oxygen at 2 liters and</p>		<p>in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility does inform each resident who is entitled to Medicaid benefits in writing at the time of admission or when the resident becomes eligible for Medicaid of the items and services that are included in the nursing facility services under the state plan and for which the resident may or may not be charged. It is also our practice to prominently display written information and to provide residents and applicants for admission oral and written information about how to apply for Medicare and Medicaid benefits and how to received refunds for payments covered by such benefits. I. It is not possible to correct the cited concern for Resident A as this a past event. RN #1 was re-educated regarding the facility's policy on CPR(Cardio Pulmonary Resuscitation)/DNR (Do Not Resuscitate) immediately following this event. II. All residents clinical records have been reviewed to insure that the code status is noted. The facility realizes all residents have the potential be affected. This has been addressed by the systems described below. III. Immediately upon notification of this incident licensed nurses were re-educated on the provision of CPR based</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155566	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/17/2011
NAME OF PROVIDER OR SUPPLIER  WARSAW MEADOWS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 E PRAIRIE ST WARSAW, IN46580		
(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>required a total assist with all activities of daily living on 11/13/11.</p> <p>The next nurse's note, dated 11/13/11 at 12:40 p.m., indicated the Nurse Practitioner was updated on the resident's condition, skin cool and clammy, respirations were 28, oxygen saturation level was 90%, pulse was 128 beats per minute. The nurse's note further indicated the resident would lift her head on occasion, was unable to respond, and the Nurse Practitioner "wants resident just kept comfortable", and the Director of Nursing Services (DNS) was notified of the resident's condition.</p> <p>A nurse's note, dated 11/13/11 at 1:43 p.m., indicated the resident was found "without respirations, pulse or blood pressure, extremities cool et mottled, N.P. ( Nurse Practitioner) notified and order rec'd (received) to release body. "</p> <p>Review of the current physician orders for November, 2011, indicated the resident was a full code.</p> <p>Review of a "code classification form", dated 2/25/11, and signed by the resident, indicated the resident desired a full code to include CPR and potential transfer to hospital with physician order for possible hospital admission.</p> <p>The form also indicated the resident had no living will, no health care representative, no Power of Attorney</p>		<p>upon the resident's stated wishes. All licensed nurses were informed to follow each resident's stated advance directive, to review the advance directive during any emergent situation, and to remind the attending physician of the resident's stated advance directive upon notification of condition deterioration. A new facility policy was written regarding CPR/DNR. Licensed nurses have been educated on this policy. The interdisciplinary team will review the resident's stated code preference quarterly during care plan meetings to further insure stated wishes are followed. IV. The Director of Nursing or her designee is conducting quality improvement audits of the provision of CPR/DNR. The clinical record of any resident whose respirations have ceased is being reviewed to further insure advance directives, including CPR/DNR, were followed. The results of the quality improvement audits are being reviewed monthly during the facility quality assurance meeting.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155566	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/17/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WARSAW MEADOWS CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 300 E PRAIRIE ST WARSAW, IN46580
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>appointed, and no guardian appointed. The face sheet also indicated under the Advanced Directive section that the resident was a "Full Code. "</p> <p>A physician order, dated 11/13/11 at 12:40 p.m., indicated, "Keep resident comfortable. "</p> <p>Interviews were completed with the following staff, beginning at 11:47 a.m., on 11/16/11, and continuing through out the day on 11/16/11: LPN #'s 3,4,5,6,7,and 8, and RN #'s 2 and 4. All of the RNs and LPNs interviewed indicated there were color coded "dots" on the outside of each resident's chart to indicate the code status of the resident. All indicated the "green" dots meant the resident was a "full code" and were to receive cardiopulmonary resuscitation, and the "red" dots indicated the resident was a DNR (do not resuscitate). They also indicated comfort measures only meant to keep the resident comfortable, with various responses including: keep comfortable if the resident does not want to eat, discontinue a lot of the medications given by mouth, keep on a turning schedule, feeding per choice, moisten the resident's mouth, and give pain medications. All of the nurses interviewed indicated even if a resident was comfort measures</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155566	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/17/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WARSAW MEADOWS CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 300 E PRAIRIE ST WARSAW, IN46580
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>only, if the resident was designated as a full code, CPR would still be initiated.</p> <p>RN#1 was interviewed, at 10:24 a.m., on 11/17/11, regarding Resident A. She indicated she had worked at the facility since April, 2011. She indicated Resident A had been declining in the last month and required more and more care. She indicated on the morning of 11/13/11, she was called to the dining room during breakfast by a family member visiting another resident. She indicated she went to the dining room and Resident A was sitting at the dining room table, with her head on the table, moaning, and did not look good. She indicated one of the aides helped her put the resident to bed, she checked the resident's vital signs, and called the Nurse Practitioner. RN#1 indicated she could not remember if she got ahold of the Nurse Practitioner right away or she called later, but this would be in her nursing notes. At this time, RN#1 read the nursing notes she had documented on 11/13/11 regarding the incident, and indicated when she found the resident in the dining room, the resident was unresponsive. She indicated she didn't remember if the Nurse Practitioner was contacted prior to 9:15 a.m., on 11/13/11, as documented in the nursing notes, or if she contacted her earlier. The RN indicated the Nurse</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155566	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/17/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WARSAW MEADOWS CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 300 E PRAIRIE ST WARSAW, IN46580
--	--

(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>Practitioner had told her to keep the resident comfortable, and she thought this meant "let her die with dignity. " She indicated she didn't realize the resident was listed as a "full code" at the time of the incident because she did not look at the resident's code status on her chart. The RN indicated at 1:43 p.m., on 11/13/11, she was called to the resident's room, and the resident was cold, with mottled skin, and had no respirations, pulse, or blood pressure. She indicated she did not initiate CPR on the resident because she thought the Nurse Practitioner "said keep comfortable. " She indicated she had contacted the DNS, by phone, on 11/13/11, to inform her of the resident's condition, then indicated she could not remember if she knew the resident's code status was a full code.</p> <p>The Nurse Practitioner was interviewed, on the telephone, at 10:51 a.m., on 11/17/11. She indicated she did not keep a record of the time she received phone calls, but indicated RN #1 had called her on 11/13/11 to let her know the resident was not as alert, but she was able to get her medications in, so the Nurse Practitioner indicated she told RN#1 not to send the resident to the hospital. The Nurse Practitioner indicated she did remind RN#1 the resident was a full code and she needed to follow the guidelines,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155566	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/17/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WARSAW MEADOWS CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 300 E PRAIRIE ST WARSAW, IN46580
--	--

(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>as the resident's request had to be honored. She also indicated she would expect the RN to do a "full code" on the resident.</p> <p>The DNS was interviewed, at 11:00 a.m., on 11/17/11, and indicated she had documented a statement, regarding a phone conversation with the Nurse Practitioner, on 11/13/11, and indicated the Nurse Practitioner had told the DNS to keep the resident comfortable, and she (the Nurse Practitioner) would not expect CPR to be initiated since the Nurse Practitioner had said to keep the resident comfortable. She indicated the Nurse Practitioner did not specify in the conversation on 11/13/11 not to do CPR, but told the DNS she would not expect her to do CPR on the resident.</p> <p>The DNS indicated she did talk to RN#1 on the telephone, on 11/13/11, after the RN had notified her the resident was declining, and the DNS indicated she told RN#1 if the Nurse Practitioner told her to keep the resident comfortable that she should leave the resident in the facility and keep her comfortable, but also told the RN that Resident A was a "full code" and she should send her to the hospital if necessary.</p> <p>The DNS indicated she knew this was confusing based on what the Nurse Practitioner said in her phone</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155566	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/17/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WARSAW MEADOWS CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 300 E PRAIRIE ST WARSAW, IN46580
--	--

(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>conversation.</p> <p>The DNS indicated the facility had no policy in place for Cardiopulmonary Resuscitation and Do Not Resuscitate, prior to this incident, but had written a policy after the incident.</p> <p>Review of the ongoing investigation, provided by the DNS, on 11/16/11, entitled "Resident Abuse Investigation Report Form", dated 11/13/11 at 1:43 p.m., indicated the DNS had received a phone call and "discovery that CPR was not administered" on Resident A.</p> <p>Under the area marked as "Type of Abuse" was marked as "Neglect or injury which involved staff not following plan of care; or severe injury of unknown origin. " Investigation Notes documented by the DNS, and dated 11/14/11, indicated the DNS was contacted at approximately 12:30 p.m., on 11/13/11, by RN#1, and notified Resident A was in poor health and the Nurse Practitioner was contacted. The DNS indicated in her note that the Nurse Practitioner did not give the order to send the resident to the hospital, but wanted her to be kept comfortable. The note indicated RN#1 stated the resident was a full code status and inquired if that meant the resident should be sent to the hospital. The DNS replied to RN#1 the resident should be kept comfortable per the Nurse Practitioner's order, but a full</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155566	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/17/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WARSAW MEADOWS CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 300 E PRAIRIE ST WARSAW, IN46580
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>code status required CPR be performed if needed.</p> <p>The investigative note indicated the DNS received a phone call from RN#1 at approximately 2:00 p.m., regarding Resident's A passing, and the DNS asked RN#1 if CPR had been initiated, and 911 called. RN#1 indicated she did not initiate CPR and 911 was not called. RN#1 informed the DNS that the resident had been found cold with mottled extremities, and no vital signs, so she thought "that we were keeping her comfortable. " The DNS informed RN#1 she should have performed CPR, called 911, and continued until Emergency Medical Services arrived. The DNS also explained the difference between comfort measures and full code status versus DNR status to RN#1.</p> <p>Another investigation note, signed by the DNS, and the Nurse Practitioner, and dated 11/15/11, indicated the Nurse Practitioner stated she was notified by RN#1 regarding Resident A's decline and the Nurse Practitioner told RN#1 to keep the resident comfortable with no further orders. The Nurse Practitioner stated she did not tell RN#1 not to do CPR, but did not expect it would be done since she wanted the resident kept comfortable.</p> <p>This Federal tag relates to Complaint</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155566	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/17/2011
NAME OF PROVIDER OR SUPPLIER  WARSAW MEADOWS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 E PRAIRIE ST WARSAW, IN46580		
(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	
F0309 SS=G	<p>IN00099867.</p> <p>3.1-4(f)(5) 3.1-4(f)(7)</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to assure 1 resident (Resident A) of 3 residents reviewed for code status in a sample of 3, was provided Cardiopulmonary Resuscitation (CPR) when the resident was found without respirations or a pulse, as ordered and according to the resident's wishes.</p> <p>Findings include:</p> <p>1. The Director of Nursing Services (DNS), was interviewed, at 10:45 a.m., on 11/16/11, and indicated an incident occurred on 11/13/11 regarding Resident A. She indicated Resident A had been declining, and RN #1 had called the Nurse Practitioner, who left orders not to send the resident to the hospital, that the resident was in the process of dying and to leave the resident at the nursing home for "Comfort measures." The DNS indicated the resident was later found cold with mottled skin and RN#1 did not do CPR (Cardiopulmonary resuscitation) because</p>	F0309	<p><b>F309 483.25 PROVIDE CARE SERVICES FOR HIGHEST WELL BEING</b> It is the practice of Warsaw Meadows Care Center to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. I. It is not possible to correct the cited concern for Resident A as this a past event. RN #1 was re-educated regarding the facility's policy on CPR(Cardio Pulmonary Resuscitation)/DNR (Do Not Resuscitate) immediately following this event. II. All residents clinical records have been reviewed to insure that the code status is noted. The facility realizes all residents have the potential be affected. This has been addressed by the systems described below. III. Immediately upon notification of this incident licensed nurses were re-educated on the provision of CPR based upon the resident's stated wishes. All licensed nurses were informed to follow each resident's</p>	11/29/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155566	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/17/2011
NAME OF PROVIDER OR SUPPLIER  WARSAW MEADOWS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 E PRAIRIE ST WARSAW, IN46580		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>the nurse thought comfort measures only meant no CPR. The DNS indicated the resident was listed as a full code.</p> <p>Review of the closed record for Resident A, beginning at 1:15 p.m., on 11/16/11, indicated diagnoses including, but not limited to, mental retardation, coronary artery disease, depression, chronic obstructive pulmonary disease, dementia with behaviors, and cerebral vascular accident.</p> <p>A nurse's note, dated 11/13/11 at 7:30 a.m., indicated, "Res (resident) unresponsive to verbal stimuli T (temperature) 97.2 P (pulse) 125 R(respirations) 24 O2 (oxygen) sats (saturation) 86%, O2 2/L (liters), resident placed back to bed c (with) 2 assist, HOB(head of bed) (arrow pointing up), B/P (blood pressure) 50/palp(palpable). Skin pale, cool/dry. Unable to take any meds(medications.)</p> <p>The next nursing note, dated 11/13/11 at 9:15 a.m., indicated the Nurse Practitioner "wants resident kept comfortable." The oxygen saturation level was 97%, respirations were 24, and blood pressure 100/60. The resident's color had improved slightly and the resident was "not so ashen et (and) pale." The nurse's note further indicated the resident remained on oxygen at 2 liters and</p>		<p>stated advance directive, to review the advance directive during any emergent situation, and to remind the attending physician of the resident's stated advance directive upon notification of condition deterioration. A new facility policy was written regarding CPR/DNR. Licensed nurses have been educated on this policy. The interdisciplinary team will review the resident's stated code preference quarterly during care plan meetings to further insure stated wishes are followed. IV. The Director of Nursing or her designee is conducting quality improvement audits of the provision of CPR/DNR. The clinical record of any resident whose respirations have ceased is being reviewed to further insure advance directives, including CPR/DNR, were followed. The results of the quality improvement audits are being reviewed monthly during the facility quality assurance meeting.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155566	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/17/2011
NAME OF PROVIDER OR SUPPLIER  WARSAW MEADOWS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 E PRAIRIE ST WARSAW, IN46580		
(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>required a total assist with all activities of daily living on 11/13/11.</p> <p>The next nurse's note, dated 11/13/11 at 12:40 p.m., indicated the Nurse Practitioner was updated on the resident's condition, skin cool and clammy, respirations were 28, oxygen saturation level was 90%, pulse was 128 beats per minute. The nurse's note further indicated the resident would lift her head on occasion, was unable to respond, and the Nurse Practitioner "wants resident just kept comfortable", and the Director of Nursing Services (DNS) was notified of the resident's condition.</p> <p>A nurse's note, dated 11/13/11 at 1:43 p.m., indicated the resident was found "without respirations, pulse or blood pressure, extremities cool et mottled, N.P. ( Nurse Practitioner) notified and order rec'd (received) to release body. "</p> <p>Review of the current physician orders for November, 2011, indicated the resident was a full code.</p> <p>Review of a "code classification form", dated 2/25/11, and signed by the resident, indicated the resident desired a full code to include CPR and potential transfer to hospital with physician order for possible hospital admission.</p> <p>The form also indicated the resident had no living will, no health care representative, no Power of Attorney</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155566	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/17/2011
NAME OF PROVIDER OR SUPPLIER  WARSAW MEADOWS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 E PRAIRIE ST WARSAW, IN46580		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>appointed, and no guardian appointed. The face sheet also indicated under the Advanced Directive section that the resident was a "Full Code. "</p> <p>A physician order, dated 11/13/11 at 12:40 p.m., indicated, "Keep resident comfortable. "</p> <p>Interviews were completed with the following staff, beginning at 11:47 a.m., on 11/16/11, and continuing through out the day on 11/16/11: LPN #'s 3,4,5,6,7,and 8, and RN #'s 2 and 4. All of the RNs and LPNs interviewed indicated there were color coded "dots" on the outside of each resident's chart to indicate the code status of the resident. All indicated the "green" dots meant the resident was a "full code" and were to receive cardiopulmonary resuscitation, and the "red" dots indicated the resident was a DNR (do not resuscitate). They also indicated comfort measures only meant to keep the resident comfortable, with various responses including: keep comfortable if the resident does not want to eat, discontinue a lot of the medications given by mouth, keep on a turning schedule, feeding per choice, moisten the resident's mouth, and give pain medications. All of the nurses interviewed indicated even if a resident was comfort measures</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155566	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/17/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WARSAW MEADOWS CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 300 E PRAIRIE ST WARSAW, IN46580
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>only, if the resident was designated as a full code, CPR would still be initiated.</p> <p>RN#1 was interviewed, at 10:24 a.m., on 11/17/11, regarding Resident A. She indicated she had worked at the facility since April, 2011. She indicated Resident A had been declining in the last month and required more and more care. She indicated on the morning of 11/13/11, she was called to the dining room during breakfast by a family member visiting another resident. She indicated she went to the dining room and Resident A was sitting at the dining room table, with her head on the table, moaning, and did not look good. She indicated one of the aides helped her put the resident to bed, she checked the resident's vital signs, and called the Nurse Practitioner. RN#1 indicated she could not remember if she got ahold of the Nurse Practitioner right away or she called later, but this would be in her nursing notes. At this time, RN#1 read the nursing notes she had documented on 11/13/11 regarding the incident, and indicated when she found the resident in the dining room, the resident was unresponsive. She indicated she didn't remember if the Nurse Practitioner was contacted prior to 9:15 a.m., on 11/13/11, as documented in the nursing notes, or if she contacted her earlier. The RN indicated the Nurse</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155566	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/17/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WARSAW MEADOWS CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 300 E PRAIRIE ST WARSAW, IN46580
--	--

(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>Practitioner had told her to keep the resident comfortable, and she thought this meant "let her die with dignity. " She indicated she didn't realize the resident was listed as a "full code" at the time of the incident because she did not look at the resident's code status on her chart. The RN indicated at 1:43 p.m., on 11/13/11, she was called to the resident's room, and the resident was cold, with mottled skin, and had no respirations, pulse, or blood pressure. She indicated she did not initiate CPR on the resident because she thought the Nurse Practitioner "said keep comfortable. " She indicated she had contacted the DNS, by phone, on 11/13/11, to inform her of the resident's condition, then indicated she could not remember if she knew the resident's code status was a full code.</p> <p>The Nurse Practitioner was interviewed, on the telephone, at 10:51 a.m., on 11/17/11. She indicated she did not keep a record of the time she received phone calls, but indicated RN #1 had called her on 11/13/11 to let her know the resident was not as alert, but she was able to get her medications in, so the Nurse Practitioner indicated she told RN#1 not to send the resident to the hospital. The Nurse Practitioner indicated she did remind RN#1 the resident was a full code and she needed to follow the guidelines,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155566	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/17/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WARSAW MEADOWS CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 300 E PRAIRIE ST WARSAW, IN46580
--	--

(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>as the resident's request had to be honored. She also indicated she would expect the RN to do a "full code" on the resident.</p> <p>The DNS was interviewed, at 11:00 a.m., on 11/17/11, and indicated she had documented a statement, regarding a phone conversation with the Nurse Practitioner, on 11/13/11, and indicated the Nurse Practitioner had told the DNS to keep the resident comfortable, and she (the Nurse Practitioner) would not expect CPR to be initiated since the Nurse Practitioner had said to keep the resident comfortable. She indicated the Nurse Practitioner did not specify in the conversation on 11/13/11 not to do CPR, but told the DNS she would not expect her to do CPR on the resident.</p> <p>The DNS indicated she did talk to RN#1 on the telephone, on 11/13/11, after the RN had notified her the resident was declining, and the DNS indicated she told RN#1 if the Nurse Practitioner told her to keep the resident comfortable that she should leave the resident in the facility and keep her comfortable, but also told the RN that Resident A was a "full code" and she should send her to the hospital if necessary.</p> <p>The DNS indicated she knew this was confusing based on what the Nurse Practitioner said in her phone</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155566	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/17/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WARSAW MEADOWS CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 300 E PRAIRIE ST WARSAW, IN46580
--	--

(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>conversation.</p> <p>The DNS indicated the facility had no policy in place for Cardiopulmonary Resuscitation and Do Not Resuscitate, prior to this incident, but had written a policy after the incident.</p> <p>Review of the ongoing investigation, provided by the DNS, on 11/16/11, entitled "Resident Abuse Investigation Report Form", dated 11/13/11 at 1:43 p.m., indicated the DNS had received a phone call and "discovery that CPR was not administered" on Resident A.</p> <p>Under the area marked as "Type of Abuse" was marked as "Neglect or injury which involved staff not following plan of care; or severe injury of unknown origin. " Investigation Notes documented by the DNS, and dated 11/14/11, indicated the DNS was contacted at approximately 12:30 p.m., on 11/13/11, by RN#1, and notified Resident A was in poor health and the Nurse Practitioner was contacted. The DNS indicated in her note that the Nurse Practitioner did not give the order to send the resident to the hospital, but wanted her to be kept comfortable. The note indicated RN#1 stated the resident was a full code status and inquired if that meant the resident should be sent to the hospital. The DNS replied to RN#1 the resident should be kept comfortable per the Nurse Practitioner's order, but a full</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155566	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/17/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WARSAW MEADOWS CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 300 E PRAIRIE ST WARSAW, IN46580
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>code status required CPR be performed if needed.</p> <p>The investigative note indicated the DNS received a phone call from RN#1 at approximately 2:00 p.m., regarding Resident's A passing, and the DNS asked RN#1 if CPR had been initiated, and 911 called. RN#1 indicated she did not initiate CPR and 911 was not called. RN#1 informed the DNS that the resident had been found cold with mottled extremities, and no vital signs, so she thought "that we were keeping her comfortable. " The DNS informed RN#1 she should have performed CPR, called 911, and continued until Emergency Medical Services arrived. The DNS also explained the difference between comfort measures and full code status versus DNR status to RN#1.</p> <p>Another investigation note, signed by the DNS, and the Nurse Practitioner, and dated 11/15/11, indicated the Nurse Practitioner stated she was notified by RN#1 regarding Resident A's decline and the Nurse Practitioner told RN#1 to keep the resident comfortable with no further orders. The Nurse Practitioner stated she did not tell RN#1 not to do CPR, but did not expect it would be done since she wanted the resident kept comfortable.</p> <p>This Federal tag relates to Complaint</p>			

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

PRINTED: 12/13/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155566	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/17/2011
NAME OF PROVIDER OR SUPPLIER  WARSAW MEADOWS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 E PRAIRIE ST WARSAW, IN46580		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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	
	IN00099867.  3.1-37(a)				