

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/09/2011	
NAME OF PROVIDER OR SUPPLIER MCKINNEY HOUSE				STREET ADDRESS, CITY, STATE, ZIP CODE 3901 HIGH STREET RD LOGANSPORT, IN46947			
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R0000	<p>This visit was for the Investigation of Complaint #IN00099146.</p> <p>Complaint #IN00099146 - Substantiated. State residential deficiencies related to the allegations are cited at R006, R052, R117 and R214</p> <p>Survey Dates: November 8 &amp; 9, 2011</p> <p>Facility Number: 004441 Provider Number: 004441 AIM Number: N/A</p> <p>Survey Team: Julie Wagoner, RN, TC Christine Fodrea, RN (November 9, 2011)</p> <p>Census bed type: Residential: 35 Total: 35</p> <p>Census Payor type: Other: 35 Total: 35</p> <p>Sample: 7</p> <p>These state findings are cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on November</p>	R0000	<p>Submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of facts alleged or corrections set forth on this statement of deficiencies. Their plan of correction is prepared and submitted because of requirements under state law. Please accept this plan of correction as our credible allegation of compliance. Please accept this resubmission of our plan of correction, due to your letter dated December 7, 2011 indicating that our original plan of correction reponses were indadequate or incomplete in reference to Tags R0006, and R0052. We have changed our reponses to these Tags in this resubmission (Dated 12/12/2011).</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.

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R0006	<p>16, 2011 by Bev Faulkner, RN</p> <p>(f) The resident must be discharged if the resident:</p> <p>(1) is a danger to the resident or others;</p> <p>(2) requires twenty-four (24) hour per day comprehensive nursing care or comprehensive nursing oversight;</p> <p>(3) requires less than twenty-four (24) hour per day comprehensive nursing care, comprehensive nursing oversight, or rehabilitative therapies and has not entered into a contract with an appropriately licensed provider of the resident ' s choice to provide those services;</p> <p>(4) is not medically stable; or</p> <p>(5) meets at least two (2) of the following three (3) criteria unless the resident is medically stable and the health facility can meet the resident ' s needs:</p> <p>(A) Requires total assistance with eating.</p> <p>(B) Requires total assistance with toileting.</p> <p>(C) Requires total assistance with transferring.</p> <p>Based on observation, record review, and interview, the facility failed to ensure 2 residents in a sample of 7 were appropriate for residential scope of care. (Resident C and D)</p> <p>Findings include:</p> <p>1. During the initial tour of the facility, conducted on 11/08/11 between 8:45 A.M. - 10:00 A.M., QMA (Qualified Medication Aide) #1 indicated Resident C</p>	R0006	<p>CA for residents affectedFor resident C and D the staff is scheduled as required by nurse assessment. Two person assist assigned as required. How ID other residents affectedWellness Director (WD) assessed current residents for ADL assistance. No ADL changes found. Permanent Corrective Action/Procedure Changes Wellness Director will review new admissions through Risk</p>	12/26/2011	

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	<p>was totally dependent for feeding needs, required two person assist for transferring and incontinence care needs. QMA #1 indicated the resident received Hospice services three times a week to provide bathing needs.</p> <p>Resident C was observed being provided incontinence care and being transferred from her bed to a reclining Broda chair, on 11/08/11 at 10:33 A.M. Two nursing staff, CNA's #6 and 7, were noted to roll the resident onto her side and totally clean the resident's peri area, place a clean incontinence brief on the resident, and redress the resident. The resident was noted to be very stiff and her hands and arms were contracted. She was unable to reach out and assist the staff in the incontinence care.</p> <p>The two CNAs were then noted to use a two person lift procedure to transfer the resident from her bed to the reclining chair. While the resident was noted to attempt to straighten her legs, the resident was unable to support her weight and stand during the transfer.</p> <p>Review of the clinical record for Resident C, completed on 11/09/11 at 9:30 A.M., included the most recent service plan, completed on 09/13/11, and indicated the resident required the assistance of two</p>		<p>Assessments, conducted 30 days after admission, every 6 months and/or at any significant change of condition to determine staffing levels. Staff were re-educated by the Wellness Director regarding corporate policy and state regulations on reporting any changes in condition.</p> <p><b><u>Residence will continue to staff based on level of care and acuity and will have 2 care givers when needed to provide care and transfer of residents. Wellness Director will work with Residence Director to ensure staffing needs are met.</u></b></p> <p>Monioring Residence Director (RD) will verify each Risk Assessment on admission, 30 days after admission, every 6 months and/or at any significant change of condition to determine staffing levels. Regional Director of Quality and Care Management will perform random audits monthly for 4 months and quarterly thereafter to ensure compliance.</p>				

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	<p>staff for transfers or a mechanical lift, required staff assistance for bathroom needs, and required "special attention or assistance with set up of your meal."</p> <p>A Hospice note, dated 10/04/11, indicated the resident required full staff assistance with all ADL's and required assistance with feeding.</p> <p>Interview with CNA #6 and 7, on 11/08/11 at 10:45 A.M., confirmed Resident C required staff to feed her at meals and required two staff assistance for transfer needs and incontinence care.</p> <p>2. During the initial tour of the facility, conducted on 11/08/11 between 8:45 A.M. - 10:00 A.M., QMA #1 indicated Resident D was confused, required two assist of staff to transfer to his wheelchair and two assist of staff to toilet.</p> <p>Resident D was observed being transferred from his recliner to his wheelchair and then from his wheelchair to the toilet on 11/08/11 at 11:30 A.M. The resident was noted to require the assistance of two staff as he was unable to understand and comply with a request to put both feet on the ground and stand. The resident was noted to point and extend his right foot when transferring and had balance issues in the bathroom</p>			

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	<p>when holding onto a bar as he again would not leave his right foot on the ground consistently while standing. One staff was required to assist the resident with his balance and the other staff was providing hygiene and toileting assistance.</p> <p>Interview with CNA #5, on 11/09/11 at 1:30 P.M., indicated Resident D always required the assistance of two staff and sometimes if he was especially tired in the evenings would require three staff to assist as he was "heavy."</p> <p>The clinical record for Resident D was reviewed on 11/08/11 at 10:00 A.M. The service plan on the chart, completed on 06/22/10 indicated the resident required staff assistance for toileting needs. The plan did not address the resident's transferring needs. The Nursing Comprehensive Evaluation, completed on 07/22/10, indicated the resident was dependent on staff for both toileting and transferring needs.</p> <p>3. Review of the nursing staffing schedule and interviews with CNA # 3 and QMA # 4 on 11/08/11 at 2:05 p.m., indicated there was times in the evening when there was only 1 staff member in the building. Both staff indicated Resident C and Resident D were usually in bed before</p>			

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R0052	<p>this occurred and if they needed any care, the care would have to be performed while the resident was in bed because it took two staff members to physically transfer the both residents. QMA #4 indicated the staff was much better lately than it had been as there were now at least two staff scheduled for almost all of evening and night shift where before there was only two staff for part of evening and only 1 staff for night shift.</p> <p>Review of the November nursing staffing schedule indicated there was only 1 CNA scheduled to be working in the building from 9:00 P.M., when the QMA left for the evening, until 10:00 P.M., when the night shift CNA's started working their shift.</p> <p>This state finding relates to Complaint #IN00099146</p> <p>(v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion.</p>			

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	<p>Based on observation, record review, and interview, the facility failed to ensure 2 of 3 staff working were aware of and responded timely to exit alarms to protect 1 of 3 ambulatory, confused residents in a sample of 7 from eloping and eventually falling outside of the building. (Resident B)</p> <p>Finding includes:</p> <p>During the initial tour of the facility, conducted on 11/08/11 between 8:45 A.M. - 10:00 A.M., nursing staff member #1, a QMA (Qualified Medication Aide), indicated Resident B was confused, new to the facility, ambulated independently, wandered into other resident's rooms at times, was to be checked every 30 minutes, was assisted to the toilet by staff, and assisted to bath by a home health care agency, and took an antianxiety medication at night to help her sleep.</p> <p>Resident B was observed on 11/08/11 at 11:45 A. M., ambulating into Resident C's room with her walker. The resident was redirected to the dining room by CNA #2. The resident was noted to have two bruises on each side of her face where the bottom rim of her eyeglasses rested against her face.</p> <p>The clinical record for Resident B was</p>	R0052	<p>CA for residents affected Resident B assessed for fall injury. None found. Resident reassessed for elopement risk.----- -----How ID other residents affected: Resident B was reassessed for elopement risk, and a Negotiated Service Plan was implemented.----- ----- -Permanent Corrective Action/Procedure Changes We respectfully disagree with this citation. There was no evidence of a Residents Rights-Offense. Staff responded to the alarm in a timely manner, and re-directed Resident B into the building.</p> <p><b><u>Staff were re-educated on response to alarm sounds and determining location of doors based on alarm sounds.</u></b>----- ----- MonitoringWellness Director and/or Residence Director will review elopement assessments weekly. RD will perform random monthly staff checks on corporate and state elopement procedures, exit alarm response, and pager use</p>	12/26/2011			

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	<p>reviewed on 11/08/11 at 10:28 A.M.</p> <p>Resident B was admitted to the facility from a long term care skilled facility on 09/10/11. The resident had previously lived alone and had been falling frequently while at home. The admitting diagnosis, included but were not limited to, history of CVA (cerebral vascular accident) and dementia. Review of a transfer document from the skilled facility, completed on 09/10/11, indicated the resident was at risk for falls, elopement, and wandered aimlessly.</p> <p>Review of Resident Service Notes, dated 10/07/11 at 6:30 A.M., indicated the resident was found in her room on the floor by her closet door. The resident had gotten herself out of bed and fell while trying to toilet herself.</p> <p>A service note, dated 10/08/11 at 6:00 P.M., indicated Resident B was found in another resident's room eating the other resident's candy.</p> <p>A service note, dated 10/11/11 at 2:00 P.M., indicated the physician had been notified of Resident B's wandering the hallways and not sleeping most nights.</p> <p>A service note, dated 10/14/11 at 5:15 P.M., indicated the resident was found outside on the walkway and had fallen.</p>			

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	<p>The resident's vital signs were documented and the resident did not complain of pain or discomfort.</p> <p>Interview with CNA #3, on 11/08/11 at 2:05 P.M., indicated she was working the evening of 10/14/11, but had not been involved in finding Resident B when she had gotten outside because she herself had been in a bathroom for awhile due to being sick. She indicated the two other staff working were bringing Resident B back into the building when she emerged from the bathroom. She indicated her pager was "going off" but she did not respond to the page because she was "too sick."</p> <p>Interview with QMA #4, on 11/09/11 at 11:00 A.M., indicated she had been working in the front of the building either with her medication cart or with paperwork when she heard a very "high pitched" sound. She indicated after a few minutes she started walking down the hallway trying to figure out where the sound was coming from. She indicated she found CNA #5, who had just started working at the facility, if she knew what that particular noise was or where it was coming from. CNA #5 denied recognizing the noise. QMA #4 indicated she then continued to work her way down the hallway from the front of the building</p>						

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	<p>and at the very back of the building noticed an exit door ajar and realized the noise was the audible alarm on the back exit door. She indicated she looked out the back of the facility and around the back corners of the facility and did not see any residents. She then stated she walked back up to the front of the building and was in the process of instructing CNA #3 and #5 to do a "head" count when Resident H, who resided in the second room from the front of the building, came out into the hall and notified them that a resident was outside on the sidewalk calling for help.</p> <p>Interview with CNA #5 on 11/09/11 at 1:36 P.M., indicated she was busy in a room getting Resident G ready for bed when the alarm sounded. She indicated she did not know what the alarm was for but figured one of the two other staff had set it off. She also indicated she did not have a pager to tell her where the alarm was coming from. She indicated she did not respond to the alarm because she could not leave Resident G, who required physical assistance. She indicated after awhile, QMA #4 asked her about the alarm. She indicated she told QMA #4 she did not have a pager and did not recognize the noise. She indicated after she was finished with Resident G and exited her room, QMA #4 and CNA #3</p>						

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	<p>were telling her the far "southwest" exit door was opened, when another resident came into the hallway and told them Resident B was outside. She indicated all three staff exited the building and found Resident B outside by the dumpster on the sidewalk. She had fallen and was lying on her back.</p> <p>Review of the orientation record for CNA's # 3, #5 and QMA #4 indicated only QMA #4 had been completely oriented to the building and facility policies. There was no general orientation documentation for CNA #3 and #5, both of whom had started working at the facility in the past 2 months. Interview with the facility Wellness Director, RN #6, on 11/09/11 at 2:30 P.M., indicated neither CNA #3 or #5 had been orientated to the facility yet because she had been too busy. The Administrator provided a Residence Orientation form, completed on 10/05/11, for CNA #5 and on 09/23/11 for CNA #3. The form, signed by the corporate maintenance consultant, indicated the employee had received instructions on the following systems: "...security system." It was unclear if the security system included instructions on what to do when a locked exit door was found ajar and the alarm was sounding.</p> <p>Observation of the building, completed on</p>						

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	<p>both 11/08/11 at 2:30 P.M. and 11/09/11 at 11:00 A.M., indicated the exit door in question was located at the far back corner of the building. The building was set up with in two square shapes with courtyards in the middle. Each square had four exit doors on each side, the front square had a locked, coded front door, and the very back square had two locked, alarmed exit doors. The southwest back door alarm was activated and audibly alarmed and after approximately 30 seconds the lock released and the door opened. The back of the facility faced a sidewalk, grass field, a fence, and a busy shopping area. The front of the building sloped down to a busy road and a river on the other side of the road. The distance from the southwest back door to the facility sidewalk outside the of Resident H's window and the facility dumpster was at least 100 feet. It was unknown how long the alarm had been activated nor how long Resident B had been outside before staff were alerted of her whereabouts.</p> <p>This state finding relates to Complaint #IN00099146</p>						

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R0117	<p>(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.</p> <p>Based on observation, record review, and interview, the facility failed to ensure there was sufficient licensed nursing staff to meet the needs of the residents.</p> <p>Finding includes:</p> <p>1. The clinical record for Resident B was reviewed on 11/08/11 at 10:28 A.M. A Resident Service Note, dated 10/14/11 at 5:15 P.M., completed by QMA #5, indicated the resident had fallen outside of the facility on the walkway. The resident</p>	R0117	<p>CA for residents affected Resident B and Resident E reassessed. No further interventions.----- -----How ID other residents affected Residents were reassessed by the Wellness Director, using the Mobility Management Assessment.----- ----- -Permanent Corrective Action/Procedure Changes Wellness Director will provide on-call 24/7 assessments</p>	12/26/2011
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	<p>had no complaints of pain and the resident's vital signs were documented. The Administrator and Wellness Director were also notified of the resident's fall. Resident Service notes on 10/15/11 at 5:00 A.M., and 11:30 A.M., were completed by a CNA and a QMA. The resident was not assessed by the Wellness Director of injuries until 10/15/11 at 1:30 P.M.</p> <p>Resident Service notes, dated 10/20/11 at 3:45 A.M., indicated the resident had fallen in her room. The Wellness Director made an entry on 10/21/11 at 4:15 P.M., but the note focused on notifying the physician of the resident's need for an increase in a medication. There was no assessment of the resident for injuries related to her fall on 10/20/11 at 3:45 A.M. Resident Service notes, dated 10/22/11 at 9:00 P.M. and 10/23/11 at 8:00 P.M., indicated the resident had a large bruise on her right arm and she was concerned about the bruise. Again there was no nursing assessment by a licensed nurse. The next Resident Service note, dated 10/26/11 at 7:45 A.M., indicated the resident now had additional bruising over her right eye. It was unknown if the resident had fallen again. The Wellness Director was notified. On 10/26/11 at 11:15 A.M., the Wellness Director assessed the resident and noted bruising to</p>		<p>as outlined in corporate policy and state regulations as needed. Staff were re-educated on corporate procedures and state regulations for reporting incidents. The Regional Director of Quality and Care Management (RDQCM) will provide back up if needed.-----</p> <p>-----</p> <p>---MonitoringResidence Director and/or Wellness Director will review incident reports at daily "stand up" meeting and perform reassessments as needed. The Regional Director of Operations will randomly review files monthly for 4 months, then quarterly thereafter to ensure compliance.</p>				

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	<p>her right eye, right knee, and right arm. The resident complained of right knee pain and was also noted to have increased confusion. The resident was sent to the emergency room and diagnoses with a contusion head injury and bruising.</p> <p>2. The clinical record for Resident E was reviewed on 11/08/11 at 1:00 P.M. Resident Service notes, dated 04/30/11 as a late entry for 04/29/11 at 7:30 P.M., completed by a certified nursing assistant indicated Resident E was found lying on the floor in the commons area. The resident complained of left hip pain, notifications were made, and the QMA gave the resident Tylenol. The resident's vital signs were also assessed. While there were vital signs and documentation of the resident's pain by Certified Nursing Assistants and/or QMAs, there was no licensed nursing assessment of Resident E until 05/02/11 at 8:00 A.M. The assessment by the Wellness Director indicated the resident's right ankle was swollen with purple bruising. She also had bruising noted to her left hip.</p> <p>Interview with the Wellness Director, RN #10, on 11/09/11 at 2:45 P.M., indicated there were sometimes, hours or days before she was able to document an assessment on residents. She indicated she was the only licensed nurse and she</p>						

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	<p>had so many responsibilities sometimes she did not remember to document the assessments she had completed and sometimes her assessments were not timely because she was not able to always be in the building.</p> <p>3. Review of the orientation record for CNA's # 3, #5 and QMA #4 indicated only QMA #4 had been completely oriented to the building and facility policies. There was no general orientation documentation for CNA #3 and #5, both of whom had started working at the facility in the past 2 months. Interview with the facility Wellness Director, RN #6, on 11/09/11 at 2:30 P.M., indicated neither CNA #3 or #5 had been orientated to the facility yet because she had been too busy. The Wellness Director, RN # 6, was the only licensed nurse employed at this facility.</p> <p>During the initial tour of the facility it was determined there were 35 residents in the facility, 5 of whom received Hospice care and 4 receiving oxygen therapy.</p> <p>This state finding relates to Complaint #IN00099146</p>						

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R0214	<p>(a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident.</p> <p>Based on record review and interview, the facility failed to ensure 2 residents with falls in a sample of 7 were assessed timely by licensed nursing staff for injuries. (Resident B and E)</p> <p>Findings include:</p> <p>1. The clinical record for Resident B was reviewed on 11/08/11 at 10:28 A.M. A Resident Service Note, dated 10/14/11 at 5:15 P.M., completed by QMA #5, indicated the resident had fallen outside of the facility on the walkway. The resident had no complaints of pain and the resident's vital signs were documented. The Administrator and Wellness Director were also notified of the resident's fall. Resident Service notes on 10/15/11 at 5:00 A.M. and 11:30 A.M. were completed by a CNA and a QMA. The resident was not assessed by the Wellness</p>	R0214	<p>CA for residents affected Resident B and Resident E reassessed. No further interventions.-----</p> <p>-----How ID oother residents affectedResidents reassessed using the Mobility Management Assessment.-----</p> <p>-----Permanent Corrective Action/Procedure ChangesWellness Director will provide on call 24/7 assessment as outlined in company policy and state regulations, as needed. Staff were re-educated on the procedure for reporting incidents and completing incident reports. The Regional Director of Quality and Care Management (RDQCM) will provide back up if needed. The Regional Director of Quality and Care Management (RDQCM) will provide back up if needed.-----</p>	12/26/2011

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	<p>Director of injuries until 10/15/11 at 1:30 P.M.</p> <p>Resident Service notes, dated 10/20/11 at 3:45 A.M. indicated the resident had fallen in her room. The Wellness Director made an entry on 10/21/11 at 4:15 P.M., but the note focused on notifying the physician of the resident's need for an increase in a medication. There was no assessment of the resident for injuries related to her fall on 10/20/11 at 3:45 A.M. Resident Service notes, dated 10/22/11 at 9:00 P.M. and 10/23/11 at 8:00 P.M. indicated the resident had a large bruise on her right arm and she was concerned about the bruise. Again there was no nursing assessment by a licensed nurse. The next Resident Service note, dated 10/26/11 at 7:45 A.M. indicated the resident now had additional bruising over her right eye. It was unknown if the resident had fallen again. The Wellness Director was notified. On 10/26/11 at 11:15 A.M., the Wellness Director assessed the resident and noted bruising to her right eye, right knee, and right arm. The resident complained of right knee pain and was also noted to have increased confusion. The resident was sent to the emergency room and diagnoses with a contusion head injury and bruising.</p> <p>2. The clinical record for Resident E was</p>		<p>-----</p> <p>-MonitoringResidence Director and/or Wellness Director will review incident reports at daily "stand up" meeting and perform reassessments as needed. The Regional Director of Operations will randomly review files monthly for 4 months, then quarterly thereafter to ensure compliance.</p>				

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

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FORM APPROVED

OMB NO. 0938-0391

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