STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155324			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 11/03/2017				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 24 TEKE BURTON DR MITCHELL, IN 47446				
(X4) ID	SUMMARVS	TATEMENT OF DEFICIENCIES	ID	T	(X5)		
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION		
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE		
	TEGOESTI ON T		1110		5.112		
F 0000 Bldg. 00	State Licensure Survey dates: October 30 and 3, 2017 Facility number: Provider number: AIM number: 10 Census Bed Typ SNF/NF: 58 Total: 58 Census Payor Ty Medicare: 11 Medicaid: 36 Other: 11 Total: 58 These deficienci cited in accordar 16.2-3.1.	31, November 1, 2, and 000217 :: 155324 00289590 e:	F 0000	This plan of correction is prepared and executed because of the provisions of State and federal law require it and not because Mitchell Manor agrees with the allegations and citations listed. Mitchell Manor maintains that the allegad deficiencies do not jeopardize the health and safety of the residents, nor is it of such character so as to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance, that the alleged deficiencies cited have been or will be corrected by the date(s) indicated. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in the following Plan of Correction. *Request paper compliance please			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

000217

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. Bl	(X2) MULTIPLE CONSTRUCTION A. BUILDING D. WING			(X3) DATE SURVEY COMPLETED	
		155324	B. W	ING		11/03/	2017
	PROVIDER OR SUPPLIER LL MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 24 TEKE BURTON DR MITCHELL, IN 47446				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F 0279 SS=D Bldg. 00	PLANS 483.20 (d) Use. A facility assessments com 15 months in the r and use the result develop, review as comprehensive ca	must maintain all resident apleted within the previous resident's active record as of the assessments to and revise the resident's are plan.					
	a comprehensive for each resident, resident rights set §483.10(c)(3), tha objectives and tim resident's medical psychosocial need comprehensive as comprehensive cafollowing -	est develop and implement person-centered care plan consistent with the forth at §483.10(c)(2) and it includes measurable reframes to meet a l, nursing, and mental and ds that are identified in the essessment. The are plan must describe the					
	attain or maintain practicable physic psychosocial well- §483.24, §483.25 (ii) Any services the required under §4 but are not provide	being as required under or §483.40; and nat would otherwise be 83.24, §483.25 or §483.40 ed due to the resident's under §483.10, including					

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPL	ETED	
		155324	B. WI	NG		11/03/	2017	
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	PROVIDER OR SUPPLIER	R			E BURTON DR			
MITCHEL	LL MANOR				ELL, IN 47446			
			1		,			
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG	`	LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIADEFICIENCY)	ΓE	DATE	
IAG		ed services or specialized	+	IAG	,		DATE	
		ices the nursing facility will						
	provide as a resul	• •						
	l :	. If a facility disagrees with						
	the findings of the	PASARR, it must indicate						
	its rationale in the	resident's medical record.						
	(i.) + + i							
	resident's represe	with the resident and the						
	resident's represe	illative (s)-						
	(A) The resident's	goals for admission and						
	desired outcomes	-						
		preference and potential						
	for future discharg	e. Facilities must r the resident's desire to						
		nunity was assessed and						
		cal contact agencies						
	1	opriate entities, for this						
	purpose.							
	(C) Discharge play	ns in the comprehensive						
		ropriate, in accordance						
		ents set forth in paragraph						
	(c) of this section.							
	Based on observ	ation, interview, and	F 02	279	F279 Comprehensive		11/22/2017	
	record review, th	ne facility failed to revise			Care Plans			
	a care plan to inc	dicate Dietician						
	recommenced nu	ıtritional drink for an			1 Pacidonts offeeted by alloged			
		reight resident for 1 of 4			1.Residents affected by alleged deficient practice:			
		ed for nutrition (Resident			*Resident's #36 and # 49 plan of			
		ea for nutrition (Resident			care were reviewed and updated as			
	1	plan was developed for			indicated on 11/21/17.			
	_	• •						
	_	ibed divalproex sodium			2) Residents at risk to be			
	`	/anticonvulsant) for			affected by alleged deficient			
		of 5 residents reviewed			practice:			
	_	medications. (Resident	1		*Other residents hav			
	49).				the potential to be affected by alleged deficient practice.	ше		
					aneged dendent practice.			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING <u>00</u>			COMPLETED	
		155324	B. WI	NG		11/03/	2017	
				GED FEET	ADDRESS OF A STATE OF CODE			
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE			
MITOLIE	LAMANIOD				E BURTON DR			
MITCHE	LL MANOR			MITCH	ELL, IN 47446			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	Findings includ	e:						
					3) Systems to ensure alleged			
	1) On 11/3/17	at 10:00 a.m., Resident			deficient practice does not recur:			
	· 1	ord was review.			1.*MDS Coordinator provide			
					one on one education to Socia			
	_	ded, but were not limited			Services on care plan complet on	liori		
		weakness, hypertension,			11/21/17.			
		tructive pulmonary			*In servicing complet	ted		
	disorder (COPE). The resident was			by all licensed nursing staff on			
	admitted on 6/2	2/17.			care plan completion on 11/21	/17.		
	Resident 36's A	dvance Directive/Medical			4) Monitoring to ensure			
	Treatment Deci	sions, signed and dated			alleged deficient practice does	3		
		ed, "I want efforts made			not recur: *Plan to be updated a	ae .		
	•				indicated.	13		
	to prolong my l				*Nursing Admin will a	udit		
	life-sustaining t	reatment to be provided."			5 orders/wk 7 days a			
					week for care plan			
	A review of Res	sident 36's weights			completion x 6 months.			
	indicated the fo	llowing:			*Ensure 100% PI			
					compliance monthly x 6			
	On 6/22/17, the	resident weighed 134			months.			
	· · · · · · · · · · · · · · · · · · ·	a BMI (Body Mass						
	Index) of 18.2.	u Bivii (Bou) iviuss						
	·	manidant mainhad 121						
	· ·	resident weighed 131						
	pounds and had							
		e resident weighed 128						
	pounds and had	a BMI of 17.4.						
	On 11/2/17, the	resident weighed 128						
	pounds and had	a BMI of 17.4						
	_							
	A review of the	Center for Disease						
	Control website, updated on 8/25/17,							
indicated a BMI below 18.5 signifies an								
	adult is underw	eight.						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l í	ULTIPLE CO JILDING	NSTRUCTION	(X3) DATE COMPL		
ANDILAN	or connection	155324	B. W		00	11/03/	
		100024				11/03/	2017
NAME OF F	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
MITCHEI	L MANOR				E BURTON DR ELL, IN 47446		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	BROWDENG N. IN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	A review of Res	ident 36's labs included					
	but were not lim	ited to the following:					
		esident's total protein range 6.4-8.0) and the					
	albumin was 2.3	(normal range 3.5-5.0).					
		sident's total protein was					
	4.8 and the albur	-					
	On 7/10/17 the r	esident's total protein					
	was 4.8 and the	albumin was 2.1.					
	On 8/17/17 the r	esident's total protein					
	was 6.1 and the	albumin was 2.8.					
	On 9/14/17 the r	esident's total protein					
	was 5.9 and the	albumin was 2.9.					
	On 9/19/17 the r	esident's total protein					
	was 5.6 and the a	albumin was 2.8.					
	On 10/10/17 the	resident's total protein					
	was 6.3 and the	albumin was 3.1.					
		resident's total protein					
	was 6.0 and the						
		resident's total protein					
	was 6.1 and the						
		resident's total protein					
	was 6.1 and the	albumin was 3.0.					
	A review of Res	ident 36's, October					
	_	per, 2017, meal intake					
		I the resident consumed					
	an average of 10	0% of meals.					
		ident 36's November,					
		orders indicated the					
	following:						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155324		· /	JILDING	nstruction <u>00</u>	(X3) DATE COMPL 11/03/	ETED	
	ROVIDER OR SUPPLIER LL MANOR		•	24 TEK	DDRESS, CITY, STATE, ZIP CODE E BURTON DR ELL, IN 47446		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	On 6/22/17, the regular diet.	resident was ordered a					
	Remeron (an ant which can increa milligrams daily A Registered Dic Collection/Assessindicated, " Control Weight body weight] 17 Res [resident] [v [cancer] wt [w indicated under v parameters. Start appetite stimular potential side effappetite Nutri	* * '					
	addressed imple Dietician's recon	drink (supplement) for					
	A review of Res indicated the following	ident 36's progress notes lowing:					
		a.m., "Admit Note: and to facility with the					

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155324	(X2) MULTIPLI A. BUILDING B. WING	E CONSTRUCTION G 00	(X3) DATE COMP: 11/03			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 24 TEKE BURTON DR MITCHELL, IN 47446					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED TO THE A	HOULD BE	(X5) COMPLETION DATE		
	Regular Diet wh room/MDR [mai Consumes 75-10 25-50% lunch, a Admit weight 13 72 inches. Conti- care]."	20 % of breakfast, and 25-75% dinner. 34 [pounds] and height nue with POC [plan of a.m., "Quarterly review: 3 [pounds]. Weight						
	change noted. Ro	e no significant weight egular Diet. Feeds self in s 75-100 % of most						
	Risk]: Continues 128 [pounds]. D	p.m., "RAR [Resident at s to be stable in weight at iet: Regular with intake f all meals Will rve."						
	regular with inta	p.m., "RAR: Diet is ke 75 to 100 % of all s 130 [pounds], stable POC."						
	included a "Nutr 9/26/17 and had There were no re the resident's car	ident 36's care plans ition" care plan, dated a target date of 12/26/17. evisions or additions to re plan to address the t loss or the Registered mmendations for						

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155324	l í	UILDING	nstruction 00	(X3) DATE COMPI 11/03.	ETED		
	PROVIDER OR SUPPLIER LL MANOR		•	STREET ADDRESS, CITY, STATE, ZIP CODE 24 TEKE BURTON DR MITCHELL, IN 47446					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B: CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E	(X5) COMPLETION DATE		
	was observed, in to eat 75% of hi observation of a on his meal tray, he has never got supplement. During an interv p.m., Certified Nassigned to the rehe was not aware receiving any numeals. During an interv p.m., the Director Resident 36 did nutritional supplement. There was no do the Resident 36's Dietician's reconnutritional fruit of the control of the 11/3/17 at 2::	the main dining room, is lunch. There was no nutritional supplement. The resident indicated iten a nutritional siew, on 11/3/17 at 3:22 fursing Assistant 1, resident's hall, indicated iten of Resident 36 tritional supplement with riew, on 11/3/17 at 3:23 for of Nursing indicated into have any current rements ordered. Cumentation revised on a care plan of the inmendations of a drink.							
	"Nutritional Interevised 7/23/09, policy currently indicated, " O	d the facility policy, rvention Program," and indicated it was the being used. The policy ngoing monitoring and ty improvement is							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155324		(X2) MUL A. BUIL B. WINC	DING	NSTRUCTION 00	(X3) DATE : COMPL 11/03/	ETED	
	PROVIDER OR SUPPLIER LL MANOR			24 TEKE	DDRESS, CITY, STATE, ZIP CODE E BURTON DR LL, IN 47446		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PF	ID REFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	team that meets	n an interdisciplinary weekly to evaluated the interventions and revise					
	49's clinical reco	t 10:43 a.m., Resident ord was reviewed. The led, but were not limited ronic depression, and ase.					
	orders dated 8/1 indicated divalpt	roex sodium 500 mg ER e) by mouth three times a					
	Administration I indicated the fol -August 2017, R divalproex sodiu behavior 8/11/17 -September 2017 divalproex sodiu behavior 9/1/17 -October 2017, I	lowing: esident 49 received om three times a day for 7-8/31/17. 7, Resident 49 received om three times a day for 9/30/17. Resident 49 received om three times a day for om three times a day for					
		ident 49's care plans address monitoring of his r, for which the					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155324	lì í	UILDING	nstruction 00	(X3) DATE COMPL 11/03/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 24 TEKE BURTON DR MITCHELL, IN 47446					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E NATE	(X5) COMPLETION DATE	
	During the intervent. The Director indicated the dia sodium was dem No documentation monitoring was a considered the Pol Administration prindicated the pol being used by the indicated,"Equaccurate and the resident behavior application of the teams's critical the determine the appropriate the polypharmacourant of the polypharmacourant in the polypharmacourant in the proposition of the polypharmacourant in the proposition of the polypharmacourant in the proposition of the propositi	provided. 245 p.m., the DON icies for Medication policy, not dated, and icy was the one currently refacility. The policy pally important as an arough assessment of a indicators, is the reinterdisciplinary painking skills to propriate plogical medication replan that supports careThe initial plogical medication replan will be reflective reators identified through resistance and						

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	OF CORRECTION OF CORRECTION 155324	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	CON	(X3) DATE SURVEY COMPLETED 11/03/2017			
	PROVIDER OR SUPPLIER LL MANOR	24 TE	STREET ADDRESS, CITY, STATE, ZIP CODE 24 TEKE BURTON DR MITCHELL, IN 47446					
(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 COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE			
F 0325 SS=D Bldg. 00	483.25(g)(1)(3) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; (3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, interview, and record review, the facility failed to revise a care plan and implement a Dietician recommended nutritional drink for an assessed underweight resident for 1 of 4 residents reviewed for nutrition (Resident 36). Findings include:	F 0325	F325 Maintain Status 1.Resident affected to deficient practice: *Resident #36 will main adequate nutrition stat *Residents primary physician/facility medic ordered a dietary cons	ntain us. cal director	11/22/2017			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l í	ULTIPLE CO JILDING	NSTRUCTION 00	(X3) DATE COMPL		
		155324	B. W	ING		11/03/	2017
NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
		•			E BURTON DR		
	_L MANOR			<u> </u>	ELL, IN 47446		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
1.40	On 6/27/17 the r was 5.2 (normal albumin was 2.3 On 7/3/17 the re 4.8 and the album On 7/10/17 the r was 4.8 and the a On 8/17/17 the r was 6.1 and the a On 9/14/17 the r was 5.9 and the a On 9/19/17 the r was 5.6 and the a On 10/10/17 the was 6.3 and the a On 10/17/17 the was 6.0 and the a On 10/24/17 the was 6.1 and the a On 10/31/17 the was 6.1 and the analysis of the seconds indicated an average of 10 A review of Res 2017 physician's following:	esident's total protein range 6.4-8.0) and the (normal range 3.5-5.0). sident's total protein was min was 2.2. esident's total protein albumin was 2.1. esident's total protein albumin was 2.8. esident's total protein albumin was 2.9. esident's total protein albumin was 2.8. resident's total protein albumin was 3.1. resident's total protein albumin was 3.1. resident's total protein albumin was 2.9. resident's total protein albumin was 2.9. resident's total protein albumin was 2.9. resident's total protein albumin was 3.0. ident 36's October per, 2017 meal intake d the resident consumed					

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i '			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	TION NUMBER: A. BUILDING		00	COMPL	ETED
		155324	B. W	B. WING			2017
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			24 TEKI	E BURTON DR		
MITCHEL	LL MANOR			MITCHE	ELL, IN 47446		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	1	ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	_	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE
	On 6/22/17 the i	resident was ordered					
	· ·	idepressant medication					
	,	•					
	which can increa	* * '					
	milligrams daily	at bedtime.					
	_	etician Nutrition Data					
		ssment, dated 6/26/17,					
	indicated, " Ci	urrent Height 72 inches,					
	Current Weight	134 [pounds], IDB [ideal					
	body weight] 17	8 pounds, BMI 18.2					
	Res [resident] [w	vith] copd, lung CA					
		veight] 134 - BMI					
	indicated under						
		ted on Remeron [an					
	•	•					
		nt] which may have					
	_	fect of [increased]					
	* *	tion Intervention: 1.)					
		drink [with] each meal					
	"						
	There were no or	rders received which					
	addressed imple	menting the Registered					
	Dietician's recon	_					
		drink (supplement) for					
	the resident's lov						
	the resident s lov	v Divil.					
	A rayiow of Dee	ident 26's progress notes					
		ident 36's progress notes					
	indicated the foll	lowing:					
	Z/00/15=						
		.m., "Admit Note:					
		ed to facility with the					
	following diagno	osis: Anorexia					
	Regular Diet wh	ich he feeds self in					

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	of correction identification number: 155324	A. BUILDING B. WING	00	COMPLETED 11/03/2017
	PROVIDER OR SUPPLIER	24 TEK	ADDRESS, CITY, STATE, ZIP CODE E BURTON DR ELL, IN 47446	
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION
TAG	room/MDR [main dining room] Consumes 75-100 % of breakfast, 25-50% lunch, and 25-75% dinner. Admit weight 134 [pounds] and height 72 inches. Continue with POC [plan of care]." 9/21/17 at 8:44 a.m., "Quarterly review: WT [weight] 133 [pounds]. Weight stable at this time no significant weight change noted. Regular Diet. Feeds self in MDR. Consumes 75-100 % of most meals" 10/12/17 at 2:06 p.m., "RAR [Resident at Risk]: Continues to be stable in weight at 128 [pounds]. Diet: Regular with intake of 75 to 100% of all meals Will continue to observe." 10/19/17 at 1:20 p.m., "RAR: Diet is regular with intake 75 to 100 % of all meals. Weight is 130 [pounds], stable Will continue to POC." A review of Resident 36's care plans included a "Nutrition" care plan, dated 9/26/17 and had a target date of 12/26/17. There were no revisions or additions to the resident's care plan to address the	TAG	DEFICIENCY)	DATE
	continued weight loss or the Registered Dietician's recommendations for nutritional fruit drink. BIMS!!!!			

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	OF CORRECTION	IDENTIFICATION NUMBER: 155324	r ´		COMPLETED 11/03/2017		
NAME OF PROVIDER OR SUPPLIER MITCHELL MANOR			2	24 TEKE	DDRESS, CITY, STATE, ZIP CODE E BURTON DR ELL, IN 47446		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID EFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	'E	(X5) COMPLETION DATE
	was observed, in to eat 75% of his observation of a on his meal tray, he has never gott supplement. During an interv	iew, on 11/3/17 at 3:22					
	assigned to the re	fursing Assistant 1, esident's hall, indicated e of Resident 36 tritional supplement with					
	p.m., the Directo	iew, on 11/3/17 at 3:23 r of Nursing indicated not have any current ements ordered.					
	There was no do the Resident 36's Dietician's recon nutritional fruit o	nmendations of a					
	Nursing provided "Nutritional Interevised 7/23/09, policy currently indicated, " Or continuous quali- achieved through	50 p.m., the Director of d the facility policy, rvention Program," and indicated it was the being used. The policy ngoing monitoring and ty improvement is an interdisciplinary weekly to evaluated the					

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	ID PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 00 CO.			COMPLETED 11/03/2017	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE E BURTON DR	
MITCHEL	L MANOR		MITCH	ELL, IN 47446	
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	effectiveness of i as necessary"	nterventions and revise			
	3.1-46(a)(1)				
F 0329 SS=D Bldg. 00	Each resident's dr	IS FREE FROM DRUGS ssary Drugs-General. ug regimen must be free drugs. An unnecessary			- 1
	(1) In excessive do drug therapy); or	ose (including duplicate			
	(2) For excessive (duration; or			
	(3) Without adequa	ate monitoring; or			
	(4) Without adequa	ate indications for its use;			
		e of adverse ich indicate the dose I or discontinued; or			
		ons of the reasons stated 1) through (5) of this			
	•	ropic Drugs. ehensive assessment of a y must ensure that			

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155324	(X2) MUI A. BUII B. WIN	LDING	onstruction 00	(X3) DATE S COMPL 11/03/	ETED
NAME OF PROVIDER OR SUPPLIER MITCHELL MANOR				24 TEKI	ADDRESS, CITY, STATE, ZIP CODE E BURTON DR ELL, IN 47446	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	Р	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	drugs unless the r treat a specific co documented in the (2) Residents who receive gradual do	s are not given these medication is necessary to ndition as diagnosed and e clinical record; o use psychotropic drugs ose reductions, and					
	contraindicated, in these drugs; Based on intervi- the facility failed received a medic behaviors was m behavior for 1 or	ew and record review, d to ensure a resident who eation prescribed for anonitored for a targeted f 5 residents reviewed for dication use. (Resident	F 032	29	F329 Unnecessary Drug 1.Resident affected by alleg		11/22/2017
	Findings include	::			deficient practice: *Resident # 49 plan of care reviewed and updated as indicated on 11/21/17.		
	clinical record w diagnoses include to: dementia, ch Alzheimer's dise readmission date A review of Res orders, indicated divalproex sodius stabilizer/anticor	ident 49's physician 18/11/17 (start date) Im (mood nvulsant) 500 mg ER e) by mouth three times a			2. Residents at risk to be affected by alleged deficient practice: *Other residents have the potential to be affected by the alleged deficient practice. 3. Systems to ensure alleged deficient practice does not recur: *MDS Coordinator/Director Nursing provided one on one education to Social Services on Psychopharmacological Medication Management Police	ctor	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING 00 B. WING			ETED
		155324	B. W				2017
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			E BURTON DR		
MITCHE	LL MANOR				ELL, IN 47446		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG			DATE
		ident 49's Medication			and Procedure on 11/21/17. *	in	
	Administration l	Records (MARs)			servicing completed by all licensed nursing staff on		
	indicated the fol	lowing:			Psychopharmacological		
	-August 2017, R	Resident 49 received			Medication. Management on		
	divalproex sodiu	im three times a day for			11/21/17.		
	behavior 8/11/17	•					
		7, Resident 49 received					
	-	im three times a day for			4. Monitoring to ensure		
	behavior 9/1/17-	,			alleged deficient practice does not recur:		
		Resident 49 received			recur.		
	-				*Plan to be updated as		
	_	im three times a day for			indicated.		
	behavior 10/1/17	/-10/31/17.					
					*Social Services/Designee		
	The clinical reco	ord lacked documentation			will audit 5 orders/wk 7 days a		
	which indicated	targeted behaviors for					
	which the medic	cation was prescribed			week for		
	were monitored	for Resident 49's			Psychopharmacological Medication		
	divalproex sodiu	ım.			Management x 6 months.		
	•				*Ensure 100% PI compliance	ء ا	
	During the inter	view, on 11/3/17 at 2:46			monthly x 6 months.		
	_	or of Nursing (DON)					
		ignosis for the divalproex					
		_			Date of compliance:		
		nentia and not behaviors.			11/22/17		
	No documentation						
	monitoring was	provided.					
		:45 p.m., the DON					
	provided the Mo	ood Stabilizers policy,					
	dated 6/21/16, as	nd indicated the policy					
	was the one curr	ently being used by the					
		olicy indicated, "Some					
		sed for seizure disorders					
		a) are sometimes used in					
	`						
	psychiatric disor	rders such as bipolar					

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 00 COMPL						
		155324	B. WINC	·		11/03/	2017
	ROVIDER OR SUPPLIER			24 TEKE	DDRESS, CITY, STATE, ZIP CODE E BURTON DR ELL, IN 47446		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	CATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID REFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
F 0364 SS=E	aggressive behave disorder. They a mood stabilizers psychotropic effects. 3.1-48(a)(3) 483.60(d)(1)(2) NUTRITIVE VALUE	E/APPEAR,					
Bldg. 00	provides- (d)(1) Food prepar conserve nutritive appearance; (d)(2) Food and drattractive, and at a temperature; Based on observe record review, the provide food that 30 resident's (Re Resident 63, Res 41) interviewed of	eives and the facility ed by methods that value, flavor, and ink that is palatable, asafe and appetizing ation, interview, and e facility failed to a was palatable for 5 of sident 65, Resident 28, ident 22 and Resident during Stage I and 9 of o reside at the nursing	F 036	4	F364 Nutritive Value/Appear, Palatable/Prefer Temp 1.Residents affected by alleged deficient practice: *Resident's #65, #28, #63, #22, and #41 will receive palatable food. *Resident's #65, #28, #63, #22, and #41 met with the activities director (resident council) to review current meals and food committee.		11/22/2017

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>			COMPLETED	
		155324	B. W	ING		11/03/2017	
				STREET /	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹					
MITCHE	I MANOD				E BURTON DR		
MILICHE	LL MANOR			MITCH	ELL, IN 47446		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	On 10/31/2017,	during Stage I, the			Residents at risk to		
	following interv				be affected by alleged		
		F-1000			deficient practice:		
	A. 0.27 D.	.: 1 (5 : 1: 1 d) .			*Other residents		
		sident 65 indicated the			have the potential to be		
	food in the facili	ty is "not very good."			affected by the alleged		
					deficient practice.		
	At 10:20 a.m., R	esident 28 indicated the					
		ity is "not consumable."			3) Systems to ensure alleged		
					deficient practice does not recur:		
	A. 11.25 D	1			1.*SDC to in service all		
		Lesident 63 indicated the			dietary staff on meal		
	food in the facili	ty is "not very good."			preparation/presentation on	,	
					11/22/2017		
	At 2:00 p.m., Re	esident 22 indicated the			*Monthly food		
	food in the facili	ty is "not very good."			committee meeting open to		
		, , ,			residents. Next meeting	all	
	Om 11/2/2017 at	11.15 a.m. Dagidant 41					
		11:15 a.m., Resident 41			scheduled on 11/28/17.		
		od in the facility is "not			4) Manitarina ta anaun		
	very good."				4) Monitoring to ensur		
					alleged deficient practice do	bes	
	On 11/3/2017 at	12:05 p.m., a lunch test			not recur:		
		d. The menu included,			*Plan to be update	d	
	1 -	ted to, roast beef. The			as indicated.		
		· · · · · · · · · · · · · · · · · · ·			l		
		bserved to be tough and			*CDM/Dietician/Designee w		
	unable to be cut	or chewed.			audit 3 test trays/wk 7 days		
					а		
	On 11/3/2017 at	12:15 p.m., the			week for palatable		
	Administrator in	dicated "if you can't cut			food x 6 months.		
		en you probably cannot			*Ensure 100% PI		
		inistrator was observed			compliance monthly x 6		
					months.		
		eut the roast beef with a					
	fork and indicate	ed "it was tough."			Date of compliance:		
					11/22/17		
	Random intervie	ews were conducted on					
	11/3/2017 at 12·	30 p.m., after residents					
	1 - 1, 5, 20 1 / 41 12.	r, arror robiacino	1		İ	I	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155324	(X2) MUL A. BUII B. WING	DING	NSTRUCTION 00	(X3) DATE : COMPL 11/03/	ETED
NAME OF PROVIDER OR SUPPLIER MITCHELL MANOR				24 TEKE	DDRESS, CITY, STATE, ZIP CODE E BURTON DR ELL, IN 47446		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	observed to have the meat was too to cut or eat the sobserved to be lead uneaten. Review of the R Minutes from 8/dietary concerns Meat tuff [sic] at Residents not repick from menu. On 11/3/2017 at Administrator proposervice and Dining indicated it was used by the facil " Serve the means.	3:05 p.m., the rovided the policy, "Food ing" undated, and the policy currently being ity. The policy indicated, eal to each resident just to have a meal served			*Request paper compliance please		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155324 NAME OF PROVIDER OR SUPPLIER			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 24 TEKE BURTON DR MITCHELL, IN 47446				
MITCHE	LL MANOR			MITCHE	ELL, IN 47446		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE

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