PRINTED: 04/27/2022
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING B. WING OO NAME OF PROVIDER OR SUPPLIER ALLISON POINTE HEALTHCARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION X2) MULTIPLE CONSTRUCTION A. BUILDING OO STREET ADDRESS, CITY, STATE, ZIP COD 5226 E 82ND ST INDIANAPOLIS, IN 46250 (X5) PREFIX (EACH CORRECTION GEACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 0000 COMPLETED O3/18/2022	039	OMB NO. 0938-	O			CENTERS FOR MEDICARE & MEDICAID SERVICES				
NAME OF PROVIDER OR SUPPLIER ALLISON POINTE HEALTHCARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION B. WING STREET ADDRESS, CITY, STATE, ZIP COD 5226 E 82ND ST INDIANAPOLIS, IN 46250 (X5) PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE		ATE SURVEY	ONSTRUCTION (X3) DATE	ULTIPLE CO	(X2) M	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		STATEMEN		
NAME OF PROVIDER OR SUPPLIER ALLISON POINTE HEALTHCARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION STREET ADDRESS, CITY, STATE, ZIP COD 5226 E 82ND ST INDIANAPOLIS, IN 46250 (X5) PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE		MPLETED	<u>00</u> COMI	ЛLDING	A. B	IDENTIFICATION NUMBER	AND PLAN OF CORRECTION IDENTIFICATION NUMBER			
NAME OF PROVIDER OR SUPPLIER ALLISON POINTE HEALTHCARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION 5226 E 82ND ST INDIANAPOLIS, IN 46250 (X5) PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE		/18/2022	03/18	ING	B. W	155272				
NAME OF PROVIDER OR SUPPLIER ALLISON POINTE HEALTHCARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION 5226 E 82ND ST INDIANAPOLIS, IN 46250 (X5) PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE			ADDRESS, CITY, STATE, ZIP COD	STREET A		<u> </u>				
ALLISON POINTE HEALTHCARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION INDIANAPOLIS, IN 46250 (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE						8	NAME OF PROVIDER OR SUPPLIES	NAME OF 1		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTION GEACH CORRECTION COMPLETIC ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE						CARE CENTER	ALLISON POINTE HEALTH	ALLISON		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE COMPLETIC CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE		(X5)	PROVIDER'S PLAN OF CORRECTION	ID		STATEMENT OF DEFICIENCIE	(X4) ID SUMMARY	(X4) ID		
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE	·ION	COMPLET	(EACH CORRECTIVE ACTION SHOULD BE	PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX (EACH DEFICIEN	PREFIX		
F 0000		DATE		TAG		R LSC IDENTIFYING INFORMATION				
							0000	F 0000		
Bldg. 00							- 1	Bldg. 00		
This visit was for the Investigation of Complaints $F 0000$ Preparation or execution of this				000	F 0	-				
IN00374443, IN00374918, IN00375155, and plan of correction does not			1 .			374918, IN00375155, and				
IN00375460. constitute admission or agreement							IN00375460.			
of provider of the truth of the facts			1 .							
Complaint IN00374443- Substantiated. No alleged or conclusions set forth on			_				_			
deficiencies related to the allegations are cited. the Statement of Deficiencies. The Plan of Correction is prepared						to the allegations are cited.	deficiencies related			
Complaint IN00374918- Substantiated. No and executed solely because it is			1			4918- Substantiated. No	Complaint IN00374			
deficiencies related to the allegations are cited. required by the position of Federal			_				_			
and State Law. The Plan of			The state of the s			5				
Complaint IN00375155 Substantiated. Deficiencies Correction is submitted in order to						5155 Substantiated. Deficiencies	Complaint IN00375			
related to the allegations are cite at F0637 and respond to the allegation of							_			
F0656. noncompliance cited during a							F0656.			
Complaint (IN00374443,			-							
Complaint IN00375460- Substantiated. No IN00374918, IN000375155,			IN00374918, IN000375155,			5460- Substantiated. No	Complaint IN00375			
deficiencies related to the allegations are cited. IN00375460) on 3/18/2022. Please accept this plan of			•			to the allegations are cited.	deficiencies related			
Survey dates: March 16, 17, and 18, 2022. correction as the provider's credible allegation of compliance.			correction as the provider's			h 16, 17, and 18, 2022.	Survey dates: Marc			
Facility number: 000172 The provider respectfully requests			· · · · · · · · · · · · · · · · · · ·			00172	Facility number: 00			
Provider number: 155272 a desk review with paper										
AIM number: 100267130 compliance to be considered in						67130	AIM number: 1002			
establishing that the provider is in			■							
Census bed type: substantial compliance.							Census bed type:			
SNF/NF: 135			·				SNF/NF: 135			
Total: 135							Total: 135			
Census payor type:							Census payor type:			
Medicare: 34										
Medicaid: 100							Medicaid: 100			
Other: 1							Other: 1			
Total: 135							Total: 135			
Those definionaise reflect State Findings sited in						raflaat Stata Findings sited in	These deficients:			
These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.										

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

Quality review completed on March 31, 2022

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: GUGZ11 Facility ID: 000172 If continuation sheet Page 1 of 7

	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER 155272		ECTION IDENTIFICATION NUMBER A. BUILDING 00		(X3) DATE SURVEY COMPLETED 03/18/2022	
	ROVIDER OR SUPPLIER		5226 E	ADDRESS, CITY, STATE, ZIP COD 82ND ST IAPOLIS, IN 46250		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE 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)	(X5) COMPLETION DATE	
F 0637 SS=D Bldg. 00	Chg §483.20(b)(2)(ii) Nacility determines determined, that the change in the resistance or improvement in will not normally reintervention by state standard disease-interventions, that than one area of the and requires intervention of the care Based on record reversion of the care Based on record reversion of the care Based on record reversion of the care failed to ensure a signature of the care failed	nere has been a significant dent's physical or mental rpose of this section, a e" means a major decline the resident's status that esolve itself without further off or by implementing related clinical has an impact on more the resident's health status, disciplinary review or e plan, or both.) riew and interview, the facility gnificant change Minimum t was done within 14 days of a signs of a significant change in ncluding decreased appetite, , onset of nausea and	F 0637	F 637 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident B has been dischard Identification of other reside having the potential to be affected by the same alleged deficient practice and corrective actions taken: MDS Coordinator or designed audit current residents for a significant change in status, puthe RAI Manual, to ensure a significant change Minimum E Set assessment was done with 14 days of the identified significance. Measures put in place and	ged. nts will er Data chin	

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Event ID:

GUGZ11 Facility ID: 000172

If continuation sheet

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3)			X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED	
	155272		B. W	ING _		03/18/	/2022	
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	PROVIDER OR SUPPLIE	R			82ND ST			
ALLISON POINTE HEALTHCARE CENTER					IAPOLIS, IN 46250			
	OINTETIEAETH	C. I.L. GERTEIN			T		•	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
					systemic changes made to			
		22 indicated the resident was			ensure the alleged deficient			
		appetite and fluid intake. The			practice does not recur:			
		IV)intravenous fluids be			Regional MDS Coordinator or			
	started.				designee will re-educate the N			
	A 1 1 1 1 1 1 1 0 /0	22 1 4 1 4 1 1			Lead and MDS Assistant on the			
		22 indicated the resident had			guidelines, per the RAI manua			
	been out to the hosp	pitai and returned.			identifying a significant change			
	A note dated 1/20/2	22 indicated the resident was			condition and completing the l	NID2		
		n condition-Urinary			timely.			
		•			The MDS Coordinator will atte	and		
	incontinence. IV fluids were started and labs were ordered.				clinical meeting 5 days per we			
	ordered.				to review the resident's clinica			
	A note dated 1/21/2	22 indicated the resident			documentation to identify an	! !		
		wed responsiveness,			significant change in status ar	nd		
		, tachycardia, was not drinking			schedule the MDS.	ıu		
	water, and eating li	-			Solitedate and Mize.			
	, ,				How the corrective measures	s		
	A note dated 1/25/2	22 indicated the resident was			will be monitored to ensure t			
	experiencing low b	lood pressure, and an alteration			alleged deficient practice do			
	in mental status.				not recur:			
					The following audits and /or			
	A note dated 1/27/2	22 indicated the resident			observations for 5 residents w	ill be		
	refused to get out o	f bed to her wheelchair.			conducted by the MDS			
					Coordinator or designee 2 tim	es		
		22 indicated the resident had a			per week times 8 weeks then			
	urinary tract infecti	on and was started on an			monthly x 4 months to ensure			
	antibiotic.				compliance: audit residents for			
					significant change in status, p	er		
	A note dated 2/10/22 indicated the resident was				the RAI Manual, to ensure a			
		et of dysphagia and nausea.			significant change Minimum D			
		agging on pills and was			Set assessment was done wit			
		w onset. The dysphagia was			14 days of the identified signif	icant		
	noted as acute, sude	den in onset, and ongoing.			change			
	A note dated 2/11/0	22 indicated the resident could			The results of the audit			
		ation even if crushed.						
	not swanow medica	auon even n crusned.			observations will be reported, reviewed and trended for			
	A Care Conference note dated 2/17/22 indicated				reviewed and trended for	ıality		

STATEMENT OF DEFICIENCIES X1) PROV		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPLETED	
		155272	B. W	'ING		03/18/2022	
NAME OF PROVIDER OR SUPPLIER ALLISON POINTE HEALTHCARE CENTER		•	5226 E	ADDRESS, CITY, STATE, ZIP COD 82ND ST APOLIS, IN 46250	•		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID			(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	T-	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	the resident the resident supplements, ate versuallowing medicate in her care. Hospice were discussed. A note dated 2/21/2 sent to the hospital. The Executive Direct Social Worker were Director of Nursing have a policy related assessments, but foliguidelines.	dent had lost weight, declined			Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.		
	3.1-31(d)(1)						
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implemer §483.21(b) Compr §483.21(b)(1) The implement a compcare plan for each the resident rights and §483.10(c)(3) objectives and tim resident's medical psychosocial need comprehensive as comprehensive cas following - (i) The services the attain or maintain practicable physic psychosocial well-§483.24, §483.25	n, nursing, and mental and the sthat are identified in the seessment. The seessment are plan must describe the sees at are to be furnished to the resident's highest al, mental, and being as required under					

	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER 155272		DRRECTION IDENTIFICATION NUMBER A. BUILDING <u>00</u>		(X3) DATE SURVEY COMPLETED 03/18/2022	
NAME OF PROVIDER OR SUPPLIER ALLISON POINTE HEALTHCARE CENTER			5226 E	ADDRESS, CITY, STATE, ZIP COD E 82ND ST NAPOLIS, IN 46250		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE 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)	(X5) COMPLETION DATE	
	required under §4 but are not provide exercise of rights the right to refuse (6). (iii) Any specialize rehabilitative serviprovide as a resul recommendations the findings of the its rationale in the (iv)In consultation resident's represe (A) The resident's desired outcomes (B) The resident's future discharge. I whether the reside community was as to local contact agappropriate entitie (C) Discharge plan care plan, as appr the requirements sthis section.	83.24, §483.25 or §483.40 ed due to the resident's under §483.10, including treatment under §483.10(c) d services or specialized ces the nursing facility will t of PASARR . If a facility disagrees with PASARR, it must indicate resident's medical record. with the resident and the intative(s)- goals for admission and preference and potential for facilities must document ent's desire to return to the sessed and any referrals encies and/or other s, for this purpose. In s in the comprehensive opriate, in accordance with set forth in paragraph (c) of				
	failed to ensure a re refusals of nutrition had care plans that a appropriate focus, g measurable outcom for care plans. (Res Findings include:	riew and interview, the facility sident who had repeated hydration, and medications, addressed these issues, with oals, interventions, and es for 1 resident of 4 reviewed ident D.)	F 0656	Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident D has been dischard Identification of other reside having the potential to be affected by the same alleged	ged. nts	
	were not limited to, malnutrition, sympt	.M. Diagnoses included, but congenital hydrocephalus, oms involving cognitive eness, irritable bowel		deficient practice and corrective actions taken: MDS Coordinator or designed audit current residents for		

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Event ID:

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	AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155272		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/18/2022
NAME OF I	PROVIDER OR SUPPLIEF	· {		T ADDRESS, CITY, STATE, ZIP COD	•
ALLISON	ALLISON POINTE HEALTHCARE CENTER			E 82ND ST NAPOLIS, IN 46250	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL PLICE IDENTIFYING INFORMATION	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	COMPLETION DATE
IAG		ATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) , gastro-esophageal reflux disease, and repeated refusals of care to ensure			
	hypertension.	sopriagear retrait disease, and		a care plan is in place with a	
				appropriate focus, goal,	
		ss notes for Resident D		interventions and measurabl	e
	indicated:			outcomes.	
	A noted dated 1/20/	/22 indicated the resident was		Measures put in place and	
	not drinking fluids,	even with encouragement.		systemic changes made to	
				ensure the alleged deficien	
		/22 indicated the resident was		practice does not recur:	
		tinuously but would not drink,		Regional Director of Clinical	
	was eating 20% (percent) of her meals or less, and			designee will re-educate the	
	the family had been	i made aware.		Lead, MDS Assistant and DO	
	A noted dated 1/25/22 indicated the resident			the facility policy for Plan of 0	care.
	refused to be weighed.			The MDS Coordinator, DON	and
	8			designee will attend clinical	
	A noted dated 1/27/	/22 indicated the resident		meeting 5 days per week to	review
	refused to get up in	her wheelchair, choosing to		the resident's clinical	
	lay in bed.			documentation to identify an	y
				refusals of care to ensure a	
		/22 indicated the resident was		plan is in place with an appro	
	seen for loss of appetite and not drinking enough fluids.			focus, goal, interventions and measurable outcomes.	
	nuius.			measurable outcomes.	
		/22 indicated the resident was		How the corrective measure	es
	consuming only 5%	of her meals with very little		will be monitored to ensure	the
	fluid intake.			alleged deficient practice d	oes
	A mote 1 1-4 10/10	/22 in directed 41 1		not recur:	
	A noted dated 2/13/ refused medications	/22 indicated the resident		The following audits and /or observations for 5 residents	will bo
	refused inedications	5.		conducted by the MDS	WIII DE
	A noted dated 2/14/	/22 indicated the resident		Coordinator or designee 2 tir	nes
	refused medications			per week times 8 weeks ther	
				monthly x 4 months to ensur	
	A noted dated 2/15/	/22 indicated the resident		compliance: audit residents	
	refused medications	S.		repeated refusals of care to	
				a care plan is in place with a	n
		/22 indicated the resident		appropriate focus, goal,	
refused medications at two separate times.			interventions and measurabl	e l	

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

PRINTED: 04/27/2022 FORM APPROVED OMB NO. 0938-039

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. B	A. BUILDING 00			COMPLETED	
		155272	B. W	ING		03/18	/2022	
		1		_				
NAME OF P	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP COD			
					82ND ST			
ALLISON	I POINTE HEALTH	CARE CENTER		INDIAN.	APOLIS, IN 46250			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	BROWINERIC PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION	
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IIE.	DATE	
					outcomes.			
	Resident D's care n	lans, which have a final			Gatosinico.			
		3/2022, contain no focus or						
		related to Resident D's			The results of the audit			
	_	g medications, hydration,			observations will be reported,			
		-			•			
	_	ioning, including appropriate			reviewed and trended for			
		ions, with measurable			compliance thru the facility Qu	ıallıy		
	objectives and time	irames.			Assurance Committee for a			
	TI E (B'	(D: (CM : 1			minimum of 6 months then			
		ector, Director of Nursing, and			randomly thereafter for further			
	Social Worker were interviewed on 3/18/21 and the issue of Resident D's care plans was				recommendation.			
		d any further information to						
	provide.							
	A maliary titlad "Car	no Plan Overviewell dated						
		re Plan Overview" dated ed from the Director of Nursing						
		2						
	on 3/18/22 at 11:00	A.M. It indicated:						
	"Definitions: for the	e purpose of this policy the						
		Care Plan is the written						
		for a resident that is						
		id provides for optimal						
	personalized care.	provides for optimal						
	personanzeu care.							
	Policy: It is the poli	icy of this facility to provide						
	resident centered ca							
		ical, and emotional needs and						
	concerns of the resi							
	concerns of the resi	aciio						
	Procedure d The	facility will:Review care						
		cant changes in care."						
	Pianowith signific	cant changes in care.						
	This Federal tag rel	lates to Complaint IN00375155.						
	Timo i caciai tag ici							
	3.1-35(a)							
			-					

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