STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155649	A. BUILDING 00 B. WING	01/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MCCORMICK'S CREEK REHABILITATION AND HEALTHCARE	210 STATE HWY 43 SPENCER, IN 47460

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00396323 and IN00395252. Complaint IN00396323 - Substantiated. Federal/State deficiencies related to the allegations are cited at F676. Complaint IN00395252 - Unsubstantiated due to lack of evidence. Survey dates: December 27, 28, 29, 30, 2022 and January 3, and 4, 2023 Facility number: 010478 Provider number: 155649 AIM number: 200197620 Census Bed Type: SNF/NF: 71 Total: 71 Census Payor Type: Medicare: 8 Medicaid: 47 Other: 16 Total: 71 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed January 9, 2023.	F 0000	**The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
sara mitchell	administrator	01/27/2023

Any defiencystatement 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155649	A. BUILDING 00 B. WING	01/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MCCORMICK'S CREEK REHABILITATION AND HEALTHCARE	210 STATE HWY 43 SPENCER, IN 47460

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	§483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155649	A. BUILDING 00 B. WING	01/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MCCORMICK'S CREEK REHABILITATION AND HEALTHCARE	210 STATE HWY 43 SPENCER, IN 47460

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	(E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155649	A. BUILDING 00 B. WING	01/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MCCORMICK'S CREEK REHABILITATION AND HEALTHCARE	210 STATE HWY 43 SPENCER, IN 47460

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). Based on interview and record review, the facility failed to ensure the Notice of Transfer or Discharge were provided to the residents or resident representatives for 2 of 2 residents reviewed for discharge.(Resident 125, Resident 15) Findings include: 1. On 1/3/23 at 2:55 p.m., Resident 125's clinical record was reviewed. The progress notes indicated the resident was sent to the hospital on 10/10/22. There was no documentation the resident or resident's representative had been provided the Notice of Transfer or Discharge. 2. On 1/3/23 at 2:55 p.m., Resident 15's clinical record was reviewed. The progress notes indicated the resident was sent to the hospital on 10/4/22 and 11/29/22. There was no documentation the resident or resident's representative had been provided the Notice of Transfer or Discharge.	F 0623	**F 623 Notice Requirements before Transfer/Discharge** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	01/20/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155649	A. BUILDING 00 B. WING	01/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MCCORMICK'S CREEK REHABILITATION AND HEALTHCARE	210 STATE HWY 43 SPENCER, IN 47460

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	During an interview on 1/4/22 at 3:00 p.m., the Executive Director indicated the notice of transfer requirements had been sent to the hospital with the resident's paperwork. There was no other documentation or policy available for review. On 1/4/23 at 3:00 p.m., the Executive Director provided the facility policy, "Notice Requirements before Transfer/Discharge," undated, and indicated it was the policy currently being used. A review of the policy indicated, "It is the policy of the facility to notify the resident and or their legal guardian of the before [sic] transfer and/or discharge according to state and federal regulations..." 3.1-12(a)(8)(D)		**1)Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Information obtained for residents identified in the 2567 was taken from record review. Those residents no longer reside within the facility or have returned back from their hospital stay. Mailed notice of transfer or discharge to responsible party. **2.) Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: Those residents identified to have been discharged/transferred or LOA within the last 30 days were reviewed.(attachement A) Notice of transfer discharge was reviewed and mailed to residents responsible party. **3.) Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** Education provided by the Director of Nursing/designee to licensed nursing staff on documentation of Notice of transfer or discharge policy for discharges/transfers and loa, to be given to resident upon discharge/transfer/LOA and copy of the Notice of transfer or discharge to be mailed to responsible parties. Licensed facility staff will review the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155649	A. BUILDING 00 B. WING	01/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MCCORMICK'S CREEK REHABILITATION AND HEALTHCARE	210 STATE HWY 43 SPENCER, IN 47460

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			requirements on the component of F 623. (attachement b) **4)How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The responsible party for this plan of correction is the Director of Nursing with Executive Director oversight or designee. Audit(attachment C) will be conducted during daily stand-up meeting, 5 days weekly to determine accuracy of Notice of transfer or discharge policy provided and mailed and the documentation of said provision. Identification of issues will result in notification of resident/responsible party for review. 1-1 education will be provided to nursing staff related to any identified issues. Notice of transfer or discharge policy audit results will be reviewed in monthly Quality Assurance/Performance Improvement meetings for a minimum of 6 months and or until 100% compliance is met for 3 months and the IDT determines substantial compliance has been achieved. **5. Date of Correction** 1/20/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155649	A. BUILDING 00 B. WING	01/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MCCORMICK'S CREEK REHABILITATION AND HEALTHCARE	210 STATE HWY 43 SPENCER, IN 47460

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
F 0625 SS=D Bldg. 00	483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. Based on interview and record review, the facility failed to ensure that a bed hold policy was provided to residents that transferred to the hospital for 2 of 2 residents reviewed for hospitalization. (Resident 125, Resident 15) Findings include:	F 0625	**F 625 Notice of Bed Hold Policy Before/Upon Transfer** **1.)Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Information obtained for residents identified in the 2567	01/20/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155649	A. BUILDING 00 B. WING	01/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MCCORMICK'S CREEK REHABILITATION AND HEALTHCARE	210 STATE HWY 43 SPENCER, IN 47460

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	1. On 1/3/23 at 2:55 p.m., Resident 125's clinical record was reviewed. The progress notes indicated the resident was sent to the hospital on 10/10/22. Review of the resident's clinical record revealed no documentation that a bed-hold policy permitting the resident to return and resume resident in the facility was provided to the resident or resident's representative. 2. On 1/3/23 at 2:55 p.m., Resident 15's clinical record was reviewed. The progress notes indicated the resident was sent to the hospital on 10/4/22 and 11/29/22. Review of the resident's clinical record revealed no documentation that a bed-hold policy permitting the resident to return and resume resident in the facility was provided to the resident or resident's representative. During an interview on 12/30/22 at 1:16 p.m., the Executive Director indicated the bed-hold policy was sent to the hospital with the resident. There was no other documentation or policy available for review. 3.1-12(a)(26)		was taken from record review. Those residents no longer reside within the facility or have returned back from their hospital stay. **2.) Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: Those residents identified to have been discharged/transferred or LOA within the last 30 days were reviewed.(attachement A) Discharge/transfer/LOA bed hold policy was reviewed and mailed to residents responsible party. **3.) Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** Education provided by the Director of Nursing/designee to licensed nursing staff on documentation of bed hold policy for discharges/transfers and loa, to be given to resident upon discharge/transfer/LOA and copy of bed hold policy to be mailed to responsible parties. Licensed facility staff will review the requirements on the component of F 623. (attachement b) **4)How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The responsible party for this plan of correction is the Director of Nursing with Executive	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155649	A. BUILDING 00 B. WING	01/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MCCORMICK'S CREEK REHABILITATION AND HEALTHCARE	210 STATE HWY 43 SPENCER, IN 47460

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			Director oversight or designee. Audit(attachment C) will be conducted during daily stand-up meeting, 5 days weekly to determine accuracy of discharge bed hold policy provided and mailed and the documentation of said provision. Identification of issues will result in notification of resident/responsible party for review. 1-1 education will be provided to nursing staff related to any identified issues. Discharge bed hold policy audit results will be reviewed in monthly Quality Assurance/Performance Improvement meetings for a minimum of 6 months and or until 100% compliance is met for 3 months and the IDT determines substantial compliance has been achieved. **5. Date of Correction** 1/20/2023	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155649	A. BUILDING 00 B. WING	01/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MCCORMICK'S CREEK REHABILITATION AND HEALTHCARE	210 STATE HWY 43 SPENCER, IN 47460

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155649	A. BUILDING 00 B. WING	01/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MCCORMICK'S CREEK REHABILITATION AND HEALTHCARE	210 STATE HWY 43 SPENCER, IN 47460

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	(iii) Be culturally-competent and trauma-informed. Based on observation, interview, and record review, the facility failed to ensure the resident had a care plan developed for insulin and antipsychotic medication use for 1 of 5 residents reviewed for unnecessary medications. (Resident 64) Finding includes: On 12/30/22 at 12:19 p.m., Resident 64 was observed to be watching her television. On 1/4/23 at 9:49 a.m., Resident 64 was observed to be lying in her bed asleep. On 12/29/22 at 3:06 p.m., Resident 64's clinical record was reviewed. The diagnoses included, but were not limited to, diabetes mellitus, schizoaffective disorder bipolar type, and psychosis. Resident 64's January 2023 Physician Orders included, but were not limited to: - Insulin glargine solution (long acting insulin), inject 10 units subcutaneously at bedtime for diabetes mellitus, initiated 11/7/22. - Quetiapine fumarate 25 mg (milligrams) tablet (antipsychotic medication) by mouth at bed time for schizoaffective disorder bipolar type, initiated 11/7/22. Resident 64's clinical record lacked documentation of a diabetes mellitus care plan for the use of insulin and a psychosis care plan for the use of quetiapine fumarate medication.	F 0656	**F656 Develop/Implement Comprehensive Care Plans** **The facility request paper compliance for this citation** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Identified resident #64 was assessed and care plans reviewed and revised for accuracy. **2) How the facility identified other residents:** Audit was conducted for other residents in the facility for documentation of diabetes mellitus care plan for the use of insulin and a psychosis care plan for the use of the medication. Audit will be conducted for those new residents admitted to facility for diabetes and psychosis care	01/20/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155649	A. BUILDING 00 B. WING	01/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MCCORMICK'S CREEK REHABILITATION AND HEALTHCARE	210 STATE HWY 43 SPENCER, IN 47460

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	During an interview on 1/4/23 at 3:34 p.m., the Director of Nursing (DON) indicated the clinical record lacked a care plan related to insulin and antipsychotic use. On 1/4/23 at 3:11 p.m., the Executive Director provided the facility's policy, "Care Plans Protocol, undated, and indicated this was the policy currently being used by the facility. A review of the policy indicated..."The care plan should be revised and on and on-going basis to reflect changes in the resident and the care the resident is receiving. 3.1-35(a)		plan. Care plans are initiated/reviewed upon admission,re-admission, annually, quarterly, for significant change and as needed. Baseline care plans will be reviewed within 48 hours of admission. Care plans are additionally reviewed and updated during scheduled care plan meetings. **3) Measures put into place/ System changes:** In-service conducted by MDS Coordinator for the interdisciplinary team to review procedures for development of baseline care plans and comprehensive care plan. New admission baseline care plans will be reviewed within 48 hours of admission to ensure diagnosis are reflective of resident condition. Resident care plans will be reviewed/updated on admission, readmission, change of condition, quarterly and annually, with significant change and as needed. **4) How the corrective actions will be monitored:** The Director of Nursing and MDS Coordinator will randomly review three residents 'admission records weekly ensuring that care plans have been developed that accurately reflect resident current status(attachment F) MDS coordinator will review during	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155649	A. BUILDING 00 B. WING	01/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MCCORMICK'S CREEK REHABILITATION AND HEALTHCARE	210 STATE HWY 43 SPENCER, IN 47460

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			scheduled care plan meetings to ensure care plans are reflective of resident's current status. Any issues identified will be immediately addressed. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. **5) Date of compliance:** 1/20/23	
F 0676 SS=D Bldg. 00	483.24(a)(1)(b)(1)-(5)(i)-(iii) Activities Daily Living (ADLs)/Mntn Abilities §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155649	A. BUILDING 00 B. WING	01/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MCCORMICK'S CREEK REHABILITATION AND HEALTHCARE	210 STATE HWY 43 SPENCER, IN 47460

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	§483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. Based on interview and record review, the facility failed to ensure staff provided necessary care and services consistent to the resident's needs and choices for 1 of 1 resident reviewed for ADLs (activities of daily living). (Resident B) Findings include: During an interview on 12/30/22 at 12:17 p.m., Resident B indicated she did not receive consistent showers while she resided at the facility. On 12/30/22 at 12:30 p.m., Resident B's closed clinical record was reviewed. The diagnoses included, but were not limited to, fracture of left talus (broken leg), person injured in motor-vehicle accident, injury of head, pain in left ankle and joints of left foot, and acute pain due to trauma. An Admission MDS (Minimum Data Set) assessment, dated 4/12/22, indicated the resident was cognitively intact and required the supervision of 1 staff member with personal	F 0676	**F 676 Activity of Daily Living** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1)Corrective actions accomplished for those residents found to be affected by the alleged deficient**	01/20/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155649	A. BUILDING 00 B. WING	01/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MCCORMICK'S CREEK REHABILITATION AND HEALTHCARE	210 STATE HWY 43 SPENCER, IN 47460

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	hygiene. A care plan, dated 4/6/22, indicated the resident was at risk for self-care deficit as evidenced by the resident needed assistance with ADLs. An intervention included staff supervision with personal hygiene. The clinical record indicated the resident was scheduled for showers on Wednesdays and Saturdays. A review of the resident's bathing/shower logs indicated the resident did not receive a shower between 5/8/22 and 5/19/22 (discharge). This was 12 days without a shower. On 1/4/23 at 3:30 p.m., the MDS Coordinator indicated she could not find any additional documentation in regard to the resident's showers. On 12/27/22 at 2:00 p.m., the Executive Director provided the policy, "Resident Rights," updated 3/15/17, and indicated it was the policy currently being used. A review of the policy indicated, "...You have the right to ... Receive the services and/or items included in the plan of care. This Federal tag relates to Complaint IN00396323. 3.1-38(a)(2)(A)		**practice:** Information obtained for residents identified in the 2567 was taken from record review. This resident no longer resides in the facility. **2.) Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: Those residents identified to have been affected were audited for receiving showers twice weekly. (Attachement G) **3.) Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** DON or designee will audit showers(attachment I) daily 5 days per week to ensure showers were given and documented. Education provided by the Director of Nursing/designee to licensed nursing staff on ensuring showers are completed and charted. Educate staff that showers are completed and documented. (Attachment H) Licensed facility staff will review the requirements on the component of F 676. **4)How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The responsible party for this plan of correction is the Director of Nursing with Executive Director oversight or designee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155649	A. BUILDING 00 B. WING	01/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MCCORMICK'S CREEK REHABILITATION AND HEALTHCARE	210 STATE HWY 43 SPENCER, IN 47460

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			Audits will be conducted during daily stand-up meeting, 5 days weekly to determine accuracy of shower and the documentation of said provision. Identification of issues will result in notification of resident/responsible party for review. 1-1 education will be provided to nursing staff related to any identified issues. Shower audit results will be reviewed in monthly Quality Assurance/Performance Improvement meetings for a minimum of 6 months and or until 100% compliance is met for 3 months and the IDT determines substantial compliance has been achieved. **5. Date of Correction** 1/20/2023	
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155649	A. BUILDING 00 B. WING	01/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MCCORMICK'S CREEK REHABILITATION AND HEALTHCARE	210 STATE HWY 43 SPENCER, IN 47460

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	(iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.			
	Based on observation, interview, and record review, the facility failed to ensure the daily posted nurse staffing sheet had the name of the facility and the actual hours worked by staff for 9 of 9 days of daily posted nurse staffing reviewed. Findings include: During an observation on 1/4/23 at 3:39 p.m., the daily posted nursing staff sheet lacked the name of the facility or the actual hours worked. On 1/04/23 at 3:46 p.m., the staffing coordinator provided the daily posted nursing staff sheet dated 12/27/22 through 1/4/23. The daily posted nursing staff sheet, dated	F 0732	**F732 E Posted Nurse Staffing Information** **The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of**	01/20/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155649	A. BUILDING 00 B. WING	01/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MCCORMICK'S CREEK REHABILITATION AND HEALTHCARE	210 STATE HWY 43 SPENCER, IN 47460

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	12/27/22 through 1/4/23, lacked documentation of the name of the facility or the actual hours worked by staff. During an interview on 1/4/23 at 3:58 p.m., the Executive Director (ED) indicated the daily posted nursing staff sheet dated 12/27/22 through 1/4/23 lacked the name of the facility name and the total actual hours worked. She indicated they did not have a policy. They followed the federal regulations for the daily posted nursing staff sheets.		**federal and state law.** **1) Immediate action taken for those residents identified:** The staffing sheet was replaced to reflect the current days staffing. No resident was identified to have been affected. **2) How the facility identified other residents:** No residents were identified to have been affected. **3) Measures put into place/ Systemic changes:** Education provided to Executive Director and Director of Nursing on the components of F732 (attachment J).The Executive Director or designee will ensure correct daily staffing information is posted to include weekend posting prior to end of day on Fridays. 4) **How the corrective actions will be monitored:** The Executive Director/designee will verify the hours are correct and updated on the staffing sheet based on the days schedule prior to posting. The results of these audits(Attachement K) will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 100% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) D.O.C- 1/20/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155649	A. BUILDING 00 B. WING	01/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MCCORMICK'S CREEK REHABILITATION AND HEALTHCARE	210 STATE HWY 43 SPENCER, IN 47460

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to ensure wheelchair arm pads were in good repair, call light and overbed light cords were repaired, and a resident wall was clean for 8 of 24 residents reviewed for environmental. (Resident 20, Resident 45, Resident 46, Resident 59, Resident 63, Resident 60, Resident 25, and Resident 51) Findings include: 1. On 12/28/22 at 11:20 A.M. and on 1/3/23 at 2:40 P.M., the armpad coverings of Resident 20's wheelchair were observed to be cracked, revealing the underlying padding. 2. On 12/28/22 at 11:40 A.M. and on 1/3/23 at 2:50 P.M., the left armpad covering of Resident 45's wheelchair was observed to be cracked, revealing the underlying padding. 3. On 12/28/22 at 11:50 A.M. and on 1/3/23 at 2:55 P.M., the right armpad of Resident 46's wheelchair was observed to be missing. 4. On 12/28/22 at 12:05 P.M. and on 1/3/23 at 3:10 P.M., the armpad coverings of Resident 59's wheelchair were observed to be cracked, revealing the underlying padding. 5. On 12/28/22 at 12:15 P.M. and on 1/3/23 at 3:20 P.M., the armpad coverings of Resident 63's wheelchair were observed to be cracked, revealing the underlying padding.	F 0921	**F 921 D** **Safe/Functional/Sanitary/Comfortable Environ** **The facility requests paper compliance for this citation.** This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. **1)Immediate actions taken for those residents identified:** ·Identified areas were immediately fixed. ·W/C arm rest were replaced. (Audit L) ·Over the bed light cords fixed to be within reach of residents. ·The call light cord in bathroom was replaced. ·The soiled wall was cleaned. **2)How the facility identified**	01/20/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155649	A. BUILDING 00 B. WING	01/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MCCORMICK'S CREEK REHABILITATION AND HEALTHCARE	210 STATE HWY 43 SPENCER, IN 47460

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	6. On 12/28/22 at 9:43 A.M. and on 1/4/23 at 2:00 P.M., the call light cord in Resident 60's bathroom was observed to be broken, with approximately 2 inches of cord remaining. 7. On 12/28/22 at 10:25 A.M. and on 1/4/23 at 2:10 P.M., the wall next the the bed of Resident 25 was observed to be stained with a dry brown substance. 8. On 12/28/22 at 2:22 P.M., the light above the head of Resident 51's bed was observed to be broken, with approximately 2 inches of cord remaining. During an interview on 1/4/23 at 2:21 P.M., the Administrator indicated the wheelchair arm pads, bathroom call light cord, and the bed light cord were in need of repair, and the dirty wall was in need of cleaning. 3.1-19(f)		**other resident:** ·No resident was identified to have been affected related to identification of needed facility repairs. ·Audit was completed of wheelchairs, call light cords and bathroom cords and resident rooms walls. (Audit L) ·Facility wide walk through was completed by Administrator, Maintenance Director, and Housekeeping Supervisor to identify facility needed cleaning and repairs. **3)Measures put into place/ System changes:** ·Maintenance added identified needed facility repairs to Preventative Maintenance Log and with Administrator assistance prioritized needed repairs. ·Preventative Maintenance log will be reviewed and initialed weekly for completed repairs. ·New identified area of needed repairs was placed on a repair schedule. ·Educated staff to notify their supervisor should any resident voice concerns regarding Maintenance (repairs) (Inservice M) **4)How the corrective actions will be monitored:** ·Responsible party for this plan of correction is the joint effort of the Executive /Maintenance Director/ who will round together weekly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155649	A. BUILDING 00 B. WING	01/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MCCORMICK'S CREEK REHABILITATION AND HEALTHCARE	210 STATE HWY 43 SPENCER, IN 47460

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			·Identified areas requiring repair are placed on a Preventative Maintenance log for follow up. ·Audits (attachment n) will be done weekly to ensure wheelchairs and walls and cords are audited weekly. ·The results of these audits will be reviewed in QAPI monthly for 6 months and or until 90% compliance is achieved for 3 consecutive months. ·The QA Committee will then identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5)Date of compliance: 1/20/2023**	