	T OF HEALTH AND HUN R MEDICARE & MEDIC.					FO	TED: 07/28/2023 RM APPROVED IB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155676	A. BUILDING B. WING			COMPLETED 07/05/2023	
	PROVIDER OR SUPPLIER			370 E N	ADDRESS, CITY, STATE, ZIP COD MAIN ST VILLE, IN 46065		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE
E 0000							
Bldg	conducted by the In accordance with 42 Survey Date: 07/05 Facility Number: 0 Provider Number: 1002 At this Emergency 1 Community Health compliance with En Requirements for M Participating Provided 483.73	00299 155676 286940 Preparedness survey, Milner Care was found not in nergency Preparedness Iedicare and Medicaid ders and Suppliers, 42 CFR certified beds. At the time of us was 52.	E 00	000	Submission of this Plan of Correction and Credible Alleg of Compliance does not cons an admission by the certified licensed provider at Milner Community Health Care, Inc. the allegations contained in the survey report are true and accurate portrayal of the provisions of nursing care and services at this facility. Milner Community Health Care, Inc. licensed and certified provide recognizes its obligation to provide legally and medically required and services to our residents economical and efficient fash Please accept this Plan of Correction as the Credible allegation of compliance.	titute and that his d . as a r, ovide d care in an	
E 0039 SS=F	403.748(d)(2), 416	5.54(d)(2), 418.113(d)(2), 2.15(d)(2), 483.475(d)(2),					

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

*[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at

483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2)

§416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)

EP Testing Requirements

(2), §491.12(d)(2), §494.62(d)(2).

Bldg. --

TITLE (X6) DATE

07/26/2023 richard Jackson administrator

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.

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPL	
		155676	B. W	ING		07/05/	/2023
NAME OF I	PROVIDER OR SUPPLIER	. ?			ADDRESS, CITY, STATE, ZIP COD	•	
					MAIN ST		
MILNER	COMMUNITY HEA	LIH CARE	_	ROSSV	'ILLE, IN 46065		
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION DD FETY (EACH CORRECTIVE ACTION SHOULD BE			(X5)
PREFIX	*	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION RD Facilities at §494.62]:		TAG	DEFERRET		DATE
	9491.12, and ESF	ND Facilities at §494.02].					
	(2) Testing The [f	acility] must conduct					
	exercises to test the emergency plan annually. The [facility] must do all of the following:						
		full-scale exercise that is					
	community-based						
		munity-based exercise is					
		enduct a facility-based e every 2 years; or					
		ility] experiences an actual					
	. ,	ade emergency that requires					
		mergency plan, the [facility]					
		gaging in its next required					
	community-based	or individual, facility-based					
	functional exercise	e following the onset of the					
	actual event.						
	' '	ditional exercise at least					
		posite the year the full-scale					
		cise under paragraph (d)(2) s conducted, that may					
		limited to the following:					
		scale exercise that is					
	` '	or individual, facility-based					
	functional exercis	_					
	(B) A mock disast						
		ercise or workshop that is					
	_	and includes a group					
	discussion using a						
	set of problem sta	emergency scenario, and a					
	-	pared questions designed					
	to challenge an e						
	_	acility's] response to and					
		ntation of all drills, tabletop					
		nergency events, and revise					
		rgency plan, as needed.					

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Event ID:

PUWQ21 Facility ID: 000299

If continuation sheet Page 2 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155676		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE A. BUILDING COMPLETED B. WING 07/05/2023					
	PROVIDER OR SUPPLIEI			370 E N	DDRESS, CITY, STATE, ZIP COD IAIN ST ILLE, IN 46065		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	*[For Hospices at	418.113(d):] spices that provide care in					
	` '	e. The hospice must					
	-	s to test the emergency					
		ally. The hospice must do					
	the following:	iany. The heepide made as					
	•	a full-scale exercise that is					
	community based						
	_	nunity based exercise is not					
	accessible, condu	ıct an individual facility					
	based functional	exercise every 2 years; or					
		experiences a natural or					
	_ ~	ency that requires activation					
		plan, the hospital is					
		aging in its next required full					
	-	based exercise or individual					
		ctional exercise following the					
	onset of the emer						
		dditional exercise every 2					
		e year the full-scale or e under paragraph (d)(2)(i)					
		conducted, that may					
		limited to the following:					
		-scale exercise that is					
	, ,	or a facility based					
	functional exercis	-					
	(B) A mock disas						
	` '	ercise or workshop that is					
		and includes a group					
	discussion using	a narrated,					
	clinically-relevant	emergency scenario, and a					
	set of problem sta						
	• .	pared questions designed					
	to challenge an e	mergency plan.					
	(3) Testing for hos	spices that provide inpatient					
	` '	hospice must conduct					
		he emergency plan twice					
		spice must do the following:					
		an annual full-scale exercise					

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Event ID:

PUWQ21 Facility ID: 000299

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155676			UILDING	NSTRUCTION	(X3) DATE COMPI 07/05			
		PROVIDER OR SUPPLIER		-	370 E N	ADDRESS, CITY, STATE, ZIP COD MAIN ST ILLE, IN 46065		
	(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION
	TAG	that is community. (A) When a commaccessible, conduct facility-based functional exercises emergency event. (ii) Conduct an act that may include, following: (A) A second full-community-based functional exercises (B) A mock disassing a narrated, emergency scenastatements, direct questions designed emergency plan. (iii) Analyze the homaintain documer exercises, and emergency scenastatements, direct questions designed emergency plan. (iii) Analyze the homaintain documer exercises, and emergency scenastatements, direct questions designed emergency plan. (iii) Analyze the homaintain documerexercises, and emergency scenastatements, direct questions designed emergency plan. (iii) Analyze the homaintain documerexercises, and emergency scenastatements, direct questions designed emergency plan. (iii) Analyze the homaintain documerexercises, and emergency plan.	nunity-based exercise is not let an annual individual extronal exercise; or experiences a natural or ency that requires activation plan, the hospice is aging in its next required nity based or facility-based e following the onset of the editional annual exercise but is not limited to the escale exercise that is or a facility based e; or ter drill; or ercise or workshop led by a udes a group discussion clinically-relevant rio, and a set of problem red messages, or prepared ed to challenge an espice's response to and entation of all drills, tabletop nergency events and revise ergency plan, as needed. 141.184(d), Hospitals at a sat §485.625(d):] PRTF, Hospital, CAH] must a to test the emergency exercise exercise exercise.		TAG			DATE

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Event ID:

PUWQ21 Facility ID: 000299

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SO				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPL	
		155676	B. W.	ING	_	07/05/	/2023
N	DROLUBER OF STATE			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	C		370 E M	MAIN ST		
MILNER	COMMUNITY HEA	LTH CARE		ROSSV	ILLE, IN 46065		
(X4) ID		STATEMENT OF DEFICIENCIE		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	DETCENCT!		DATE
		ct an annual individual, ctional exercise; or					
		Hospital, CAH] experiences					
		or man-made emergency					
		ation of the emergency					
	-	is exempt from engaging in					
		ull-scale community based					
		ty-based functional exercise					
		et of the emergency event.					
	_	an [additional] annual					
	, ,	at may include, but is not					
	limited to the follo	-					
		scale exercise that is					
	community-based						
		ctional exercise; or					
		ock disaster drill; or					
	, ,	exercise or workshop that					
	is led by a facilitat	or and includes a group					
	discussion, using	a narrated,					
	clinically-relevant	emergency scenario, and a					
	set of problem sta	tements, directed					
	messages, or pre	pared questions designed					
	to challenge an er	mergency plan.					
	(iii) Analyze tl	he [facility's] response to					
	and maintain docเ	umentation of all drills,					
		s, and emergency events					
	and revise the [fac	cility's] emergency plan, as					
	needed.						
	*[For PACE at §46	60.84(d):]					
	_	PACE organization must					
		to test the emergency					
	plan at least annu	9					
	organization must	-					
	(i) Participate in a	an annual full-scale exercise					
	that is community	-based; or					
	(A) When a comm	nunity-based exercise is not					
	accessible, condu	ct an annual individual,					
	facility-based fund	ctional exercise; or					
	(B) If the PACE ex	xperiences an actual natural					

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Event ID:

PUWQ21 Facility ID: 000299

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155676		A. BUILDING COM				survey leted /2023		
NAME (OF PROVIDER OR SUPPLIE	R	•		ADDRESS, CITY, STATE, ZIP COD	•		
MILNE	ER COMMUNITY HEA	LTH CARE	370 E MAIN ST ROSSVILLE, IN 46065					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	PROVIDER'S PLAN OF CORRECTION		
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP				
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		ergency that requires						
		emergency plan, the PACE						
		ngaging in its next required nity based or individual,						
		ctional exercise following the						
	onset of the emer	_						
		an additional exercise every						
	' '	the year the full-scale or						
		e under paragraph (d)(2)(i)						
		conducted that may include,						
	but is not limited t	to the following:						
	(A) A second full	-scale exercise that is						
		l or individual, a facility						
	based functional							
	(B) A mock disas							
		ercise or workshop that is						
		and includes a group						
	discussion, using							
		emergency scenario, and a atements, directed						
		pared questions designed						
	to challenge an e	·						
	_	PACE's response to and						
	1 ' '	ntation of all drills, tabletop						
		nergency events and revise						
	the PACE's emer	gency plan, as needed.						
	*[For LTC Facilitie	es at §483.73(d):]						
	 	ity] must conduct exercises						
	to test the emerge	ency plan at least twice per						
		announced staff drills using						
		ocedures. The [LTC facility,						
	ICF/IID] must do	<u> </u>						
	' '	an annual full-scale exercise						
	that is community							
		nunity-based exercise is not						
	 	uct an annual individual,						
	facility-based fund	ctional exercise. cility] facility experiences an						
		man-made emergency that						
	I actual Hatural Of I	nan made emergency mat					1	

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Event ID:

PUWQ21 Facility ID: 000299

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155676	(X2) MULTIPLE CO A. BUILDING B. WING	DNSTRUCTION	COM	TE SURVEY MPLETED 05/2023
	PROVIDER OR SUPPLIER		370 E N	ADDRESS, CITY, STATE, ZII MAIN ST /ILLE, IN 46065	PCOD	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
	LTC facility is exercequired a full-sca individual, facility-following the onse (ii) Conduct an act that may include, following: (A) A second full-community-based based functional et (B) A mock disas: (C) A tabletop excled by a facilitator discussion, using clinically-relevant set of problem starces and revised events, and revised events, and revised emergency plan, at (2) Testing. The IC exercises to test the twice per year. The following: (i) Participate in an that is community. (A) When a community. (A) When a community. (B) If the ICF/IID et act is activation of the exercise is exempt from en individual individual in an activation of the exercise is exempt from en individual individual in an activation of the exempt from en individual indi	ter drill; or ercise or workshop that is includes a group a narrated, emergency scenario, and a tements, directed pared questions designed mergency plan. LTC facility] facility's maintain documentation of exercises, and emergency ethe [LTC facility] facility's as needed. 483.475(d)]: CF/IID must conduct me emergency plan at least e ICF/IID must do the				

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Event ID:

 $PUWQ21 \quad \text{Facility ID:} \quad 000299$

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	JILDING		COMPL	ETED	
		155676	B. W	ING		07/05/	2023
		l .		CTDEET A	ADDRESS CITY STATE ZID COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP COD		
MILNED		LTUCADE		1			
WILNER	COMMUNITY HEA	LINCARE		RUSSV	'ILLE, IN 46065		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		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	TE.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	facility-based fund	ctional exercise following the					
	onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following:						
	(A) A second full-	scale exercise that is					
	community-based						
		ctional exercise; or					
	(B) A mock disast						
		ercise or workshop that is					
	1	and includes a group					
	discussion, using						
		emergency scenario, and a					
		tements, directed					
	-	pared questions designed					
	to challenge an er						
		CF/IID's response to and					
		ntation of all drills, tabletop					
		nergency events, and revise					
	the ICF/IID's eme	rgency plan, as needed.					
	*(F1111A+ C46	24 4001					
	*[For HHAs at §48	=					
		e HHA must conduct					
		he emergency plan at					
	following:	e HHA must do the					
		full-scale exercise that is					
	community-based						
		ommunity-based exercise					
		conduct an annual					
		based functional exercise					
	every 2 years; or.						
		A experiences an actual					
		ade emergency that requires					
		mergency plan, the HHA is					
		aging in its next required					
	full-scale community-based or individual, facility based functional exercise following the						
	onset of the emer	_					
		ditional exercise every 2					
	` ', ==========						

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

PRINTED: 07/28/2023 FORM APPROVED OMB NO. 0938-039

	IENT OF DEFICIENCIES AN OF CORRECTION	IDENTIFICATION NUMBER 155676	r í	UILDING	NSTRUCTION	COMPL 07/05/	ETED
	F PROVIDER OR SUPPLIER			370 E M	ADDRESS, CITY, STATE, ZIP COD 1AIN ST ILLE, IN 46065		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R 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
	functional exercise of this section is of include, but is not (A) A second community-based facility-based funcing (B) A mock d (C) A tabletor is led by a facilitat discussion, using clinically-relevant set of problem star messages, or preto challenge an ere (iii) Analyze the H maintain documer exercises, and enthe HHA's emerged (d)(2) Testing. The exercises to test to OPO must do the (i) Conduct a paper or workshop at lease exercise is led by group discussion, relevant emergen problem statemer prepared question emergency plan. I actual natural or requires activation OPO is exempt for required testing exercise of the emergency (ii) Analyze the Olimaintain documer	limited to the following: full-scale exercise that is or an individual, ctional exercise; or isaster drill; or o exercise or workshop that for and includes a group a narrated, emergency scenario, and a attements, directed pared questions designed mergency plan. HA's response to and attation of all drills, tabletop mergency events, and revise ency plan, as needed. 86.360] e OPO must conduct he emergency plan. The following: er-based, tabletop exercise ast annually. A tabletop a facilitator and includes a using a narrated, clinically cy scenario, and a set of ats, directed messages, or as designed to challenge an aff the OPO experiences an man-made emergency plan, the om engaging in its next exercise following the onset					

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Event ID:

PUWQ21 Facility ID: 000299

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155676			ILDING	NSTRUCTION	(X3) DATE COMPL 07/05/	ETED	
	PROVIDER OR SUPPLIEI			370 E N	ADDRESS, CITY, STATE, ZIP COD MAIN ST 'ILLE, IN 46065		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R 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
	needed. *[RNCHIs at §40. (d)(2) Testing. The exercises to test to RNHCI must do to the conduct a paper at least annually. Group discussion narrated, clinically scenario, and a sedirected message designed to challed (ii) Analyze the RI maintain document exercises, and enthe RNHCI's eme Based on record regalled to conduct explan at least twice punannounced staff procedures. The LT following: (i) Participate in an is community-based a. When a community-based a. When a community facility-based function or man-made emergof the emergency perform engaging its medical community-based of the emergency performed the onset of the action of the conset of the action of the conduct and dinclude, but is not be as a second full-scale functional a. A second full-scale functional and the onset of the action of the acti	e RNHCI must conduct the emergency plan. The ne following: er-based, tabletop exercise A tabletop exercise is a led by a facilitator, using a v-relevant emergency et of problem statements, es, or prepared questions enge an emergency plan. NHCI's response to and ntation of all tabletop nergency events, and revise regency plan, as needed. view and interview, the facility tercises to test the emergency er year, including drills using the emergency or year, including drills using the emergency or facility must do the annual full-scale exercise that dt; or ity-based exercise is not an annual individual, ional exercise. Ey experiences an actual natural gency that requires activation lan, the LTC facility is exempt ext required full-scale or individual, facility-based I exercise for I year following ual event. itional exercise that may imited to the following:	E 00	039	1. District 4 Health Care Coal contacted and assistance with table top exercise requested. Table top exercise scheduled July 26, 2023 10a-12p with assistance of the Health Care Coalition. 2. All other testing has been completed timely. 3. Bi-annual testing will be reviewed on pm schedule in December. If testing for prior is not completed, it will be scheduled within the next 3 months. 4. QAPI committee will review preventative maintenance ma annually to assure all testing i planned.	n for year v nual	07/26/2023

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

PRINTED: 07/28/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155676		r í	JILDING	NSTRUCTION	(X3) DATE COMPL 07/05 /	ETED	
	PROVIDER OR SUPPLIER			370 E M	ADDRESS, CITY, STATE, ZIP COD MAIN ST VILLE, IN 46065		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.IE	DATE
	functional exercise. b. A mock disaster c. A tabletop exerci facilitator that inclu a narrated, clinicall and a set of probler messages, or prepar challenge an emerg (iii) Analyze the LT maintain document exercises, and emer LTC facility's emer accordance with 42 deficient practice of Findings include: Based on record rev "Disaster Manual - Care" on 07/05/23 a Maintenance (DOM full-scale exercise t individual, facility- disaster drill, or tab is led by a facilitate discussion, using a emergency scenario statements, directed questions designed plan available for re the time of record r they had not yet sel second exercise as of	drill; or ise or workshop that is led by a ides a group discussion, using y relevant emergency scenario, in statements, directed red questions designed to ency plan. To facility's response to and attion of all drills, tabletop regency events, and revise the regency plan, as needed in CFR 483.73(d)(2). This bould affect all occupants. Wiew of the document entitled Milner Community Health at 11:06 a.m. with the Director of 10, there was no: second that is community-based or an based functional exercise, mock eletop exercise or workshop that or that includes a group narrated, clinically relevant to, and a set of problem it messages, or prepared to challenge an emergency eview. Based on an interview at eview, the DOM stated that needuled or conducted a					
			I				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY	
		IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
		155676	B. W	ING		07/05/	/2023
				CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	8			MAIN ST		
MILNER	COMMUNITY HEA	LTH CARE		ROSSVILLE, IN 46065			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
K 0000							
Bldg. 01			1				
	-	Recertification and State	K 0	000	Submission of this Plan of		
	-	vas conducted by the Indiana			Correction and Credible Allega	ation	
	-	th in accordance with 42 CFR			of Compliance does not const	itute	
	483.90(a).				an admission by the certified a	and	
					licensed provider at Milner		
	Survey Date: 07/05	5/23			Community Health Care, Inc t		
					the allegations contained in th	is	
	Facility Number: 0				survey report are true and		
	Provider Number:				accurate portrayal of the		
	AIM Number: 100	286940			provisions of nursing care and	İ	
					services at this facility. Milner		
	-	Code survey, Milner			Community Health Care , Inc.		
	-	Care was found not in			licensed and certified provider		
	-	equirements for Participation in			recognizes its obligation to pro		
		, 42 CFR Subpart 483.90(a),			legally and medically required		
	_	re, and the 2012 edition of the			and services to our residents i		
		etion Association (NFPA) 101,			economical and efficient fashi	on.	
		LSC) and 410 IAC 16.2. The			Please accept this Plan of		
		ved with Chapter 19, Existing			Correction as the Credible		
	Health Care Occupa	ancies.			allegation of compliance.		
	This 4 6 11	in and the control of					
	-	ity was determined to be of					
		ruction and was fully cility has a two-hour separation					
	•	-					
		ing occupancy located on the lding. The west emergency exit					
		es passing through one smoke					
	-	assisted living unit. The					
	_	arm system with hard wired					
		the corridors, spaces open to					
		all resident rooms. The					
	,	ity of 80 and had a census of					
	52 at the time of thi						
	52 at the time of thi	Survey.					
	All areas where the	residents have customary					
		ered. All areas which provide					
	-	re sprinklered except for the					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155676	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	X3) DATE SURVEY COMPLETED 07/05/2023
	PROVIDER OR SUPPLIER		370 E I	ADDRESS, CITY, STATE, ZIP COD MAIN ST VILLE, IN 46065	
(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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	storage area which a	e shed, and one garage are not sprinklered. npleted on 07/07/23			
K 0271 SS=E Bldg. 01	7.7, provides a leve the provisions of 7 changes in elevating free of obstruction discharge shall be travel surface. 18.2.7, 19.2.7 Based on observation failed to ensure the 6 delayed egress locall residents, staff, at Delayed-Egress Loca	ranged in accordance with rel walking surface meeting 7.1.7 with respect to on and shall be maintained s. Additionally, the exit a hard packed all-weather on and interview, the facility means of egress through 1 of eks was readily accessible for and visitors. LSC 7.2.1.6.1.1 eking Systems allows layed-egress locks shall be alled on door assemblies that have a proved, for fire detection system and automatic sprinkler system and automatic sprinkler system and chapters 11 through 43, shall unlock in the direction of on of one of the following: revised automatic sprinkler accordance with Section 9.7 and the direction of one of the following: revised automatic sprinkler accordance with Section 9.7 and the direction of one of the following: revised automatic fire detections	K 0271	1. Egress door sited was adjusted to proper sensitivity. 2. All other egress doors checand passed. 3. All egress doors were adder preventative maintenance schedule and will be tested monthly. 4. Maintenance Director will report preventative maintenancoutcomes monthly to QAPI Committee for 6 months.	d to

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155676		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 01 COMPLETED B. WING 07/05/2023			
	PROVIDER OR SUPPLIEF		370 E I	ADDRESS, CITY, STATE, ZIP COD MAIN ST /ILLE, IN 46065	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI	E COMPLETION
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	system in accordance				
		shall unlock in the direction of			
		power controlling the lock or			
	locking mechanism				
		process shall release the lock in			
		ess within 15 seconds, or 30			
		roved by the authority having pplication of a force to the			
		ired in 7.2.1.5.10 under all of			
	the following condi				
	•	hall not be required to exceed			
	15 lbf (67 N).	nan not be required to exceed			
		shall not be required to be			
		d for more than 3 seconds.			
		the release process shall			
		signal in the vicinity of the			
	door opening.	5			
		ock has been released by the			
		to the releasing device,			
	relocking shall be b	y manual means only.			
	(4) A readily visible	e, durable sign in letters not			
	less than 1 in. (25m	m) high and at least 1/8 in.			
	(3.2mm) in stroke v	vidth on a contrasting			
	background that rea	ds as follows shall be located			
		acent to the release device in			
	the direction of egre				
	"PUSH UNTIL AL				
		PENED IN 15 SECONDS".			
	` '	of the doors equipped with			
		s shall be provided with			
		in accordance with 7.9.			
	*	ice could affect all residents,			
	staff, and visitors.				
	Findings include:				
	Based on observation	ons made during a tour of the			
	facility on 07/05/23	with the Director of			
	Maintenance (DOM	I), at 1:56 p.m., the East Hall			
	exit near the Beauty	Shop exit was provided with			

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

PRINTED: 07/28/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155676		I .	JILDING	01	COMPL 07/05/	ETED	
NAME OF PROVIDER OR SUPPLIER MILNER COMMUNITY HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP COD 370 E MAIN ST ROSSVILLE, IN 46065				
(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 APPROPRI- DEFICIENCY)	ATE	(X5) COMPLETION DATE
K 0321 SS=E Bldg. 01	proper signage indice opened in 15 second however, when the contract interversible process initiated. This was a Maintenance Direct who added that he was soon as he could so. During the exit confunction of the contract of the could so. During the exit confunction of the could so. During the exit confunction of the could so. During the exit confunction of the could soon of the could s	or at the time of observations would have the door adjusted or contact his vendor to do Gerence with the facility me DOM at 2:18 p.m., no on or evidence could be of this deficient finding. - Enclosure eare protected by a fire pour fire resistance rating rated doors) or an inguishing system in 1.7.1 or 19.3.5.9. When the ici fire extinguishing system areas shall be separated by smoke resisting in accordance with 8.4. Follosing or and permitted to have pplied protective plates that inches from the bottom of and zone locations of					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU		SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155676	B. W	ING		07/05/2023	
				CTREET	ADDRESS SITE STATE SID COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
MILNER COMMUNITY HEALTH CARE			370 E MAIN ST ROSSVILLE, IN 46065				
WILNER	COMMUNITY HEA	LINCARE		KUSSV	TILLE, IN 40005		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		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	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Area	Automatic Sprinkler					
	Separation	N/A					
	a. Boiler and Fuel	-Fired Heater Rooms					
	b. Laundries (larg	er than 100 square feet)					
	c. Repair, Mainter	nance, and Paint Shops					
	d. Soiled Linen Ro	ooms (exceeding 64					
	gallons)						
	e. Trash Collectio						
	(exceeding 64 gal	•					
	f. Combustible Sto	orage Rooms/Spaces					
	(over 50 square fe	· ·					
		classified as Severe					
	Hazard - see K32	,					
	1 '	ation and interview, the facility	K 0	321	Automatic door closer insta	lled	07/24/2023
		corridor door to 1 of over 6			to converted resident room an	d	
	hazardous areas, su				door stop removed from Medic	cal	
		d room or a storage room of			Records office.		
		es over 50 square feet in size,			2. These are the only room fa	-	
		a self-closing device which			into sited category and all othe		
		or to automatically close and			stops have been removed fror	n	
		frame. This deficient practice			facility.		
	could affect as many as 14 residents, 4 staff and 2				3. Staff in-serviced on no doo	r	
	visitors.				stop facility policy.		
					Monthly door preventative		
	Findings include:				maintenance amended to add		
					checks on door closures and t	0	
		ons made during a tour of the			verify no door stops are being		
	· ·	s with the Director of			used.		
	•	1), at 1:47 p.m., resident room			4. Maintenance Director will n	•	
		verted into a storage room.			QAPIi Committee monthly for	6	
		d approximately 190 square feet			months.		
		ed: numerous boxes of latex					
		rns, hand sanitizer, packages of					
	· -	niscellaneous boxes of other					
		equipment and supplies. The					
		s room did not have a					
		installed on it. The lack of a					
	functioning self-clo	_					
		ne DOM at the time of					
	observation who ad	ded that he would have one					

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	OF CORRECTION	IDENTIFICATION NUMBER 155676	A. BUILDING B. WING	01	COMI	E SURVEY PLETED 5/2023
	PROVIDER OR SUPPLIER		370 E N	ADDRESS, CITY, STATE, ZIP CO MAIN ST /ILLE, IN 46065	D	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION Possible	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	Administrator and the additional information provided contrary to a 3.1-19(b) 2) Based on observation failed to ensure 1 of hazardous area were suitable for keeping impediment to closi the passage of smok could affect 14 resident facility on 07/05/23 Maintenance (DOM Records office, a rough that contained hund patient charts was possible with a door wedge of observation, the laforementioned corn was propped in the door wedge adding propopen the door, the door to this office the door to this office the door and the door additional information of the additional informati	ference with the facility he DOM at 2:18 p.m., no on or evidence could be this deficient finding. ation and interview, the facility of corridor doors to a e provided with a means the door closed, had no ng, latching, and would resist te. This deficient practice dents, 4 staff and 2 visitors. ans made during a tour of the with the Director of of on greater than 50 square feet reds of medical records and ropped in the open position Based on interview at the time DOM acknowledged the ridor door to a hazardous room fully open position with a that he has asked staff not to but they continue to do so to				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155676		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 07/05/2023	
	PROVIDER OR SUPPLIER		370 E	ADDRESS, CITY, STATE, ZIP COD MAIN ST VILLE, IN 46065	
(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
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System Maintenance Fire Alarm System Maintenance A fire alarm system in accordance with complying with the National Electric Continuational Fire Alarm Records of system and testing are readed and testing and testing and testing and testing and testing alternate with or more often if requires alternate year thereaded alternate y	n - Testing and n - Testing and m is tested and maintained n an approved program e requirements of NFPA 70, code, and NFPA 72, m and Signaling Code. n acceptance, maintenance	K 0345	1. Sited inspection results we located with appropriate sens parameters attached. 2. This was only testing data missing. 3. Testing company notified to sensitivity data needs to be attached annually to testing document. Maintenance Dire will add specific documentation needed to preventative maintenance schedule to ensproper paperwork is received. 4. QAPI committee to review is sensitivity data for the next 2 years of inspections to ensure proper documentation is presentation.	ere 07/24/2023 itivity chat cotor on ure

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155676		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 07/05/2023	
	ROVIDER OR SUPPLIER		370 E N	ADDRESS, CITY, STATE, ZIP COD MAIN ST /ILLE, IN 46065	
(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
	documentation was of the time of this stated that he would as he could schedule. During the exit confi	dition and confirmed no other available from his vendor as urvey. Furthermore, the DOM I have his vendor out as soon e the testing. ference with the facility he DOM at 2:18 p.m., no			
	additional informati provided contrary to	on or evidence could be this deficient finding.			
K 0353 SS=F Bldg. 01	Sprinkler System - Automatic sprinkler are inspected, test accordance with North Inspection, Testing Water-based Fire Records of system inspection and test secure location and secure secure sprinkler inspection and test secure secure secure sprinkler inspection and test secure secure secure sprinkler inspection and test secure se				
	coverage for any rautomatic sprinkle 9.7.5, 9.7.7, 9.7.8, Based on record revaled to maintain a accordance with NF sprinkler systems shaintained in accordance of the sprinkler systems shaintained in accordance.	-	K 0353	Contracted company notificand scheduled data retrieval needed to apply for hydraulic name plate. Company indicate they would need 30 days to	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155676		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI A. BUILDING 01 COMPLETED B. WING 07/05/2023			
	PROVIDER OR SUPPLIER		370 E I	ADDRESS, CITY, STATE, ZIP COD MAIN ST VILLE, IN 46065	
(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 APPROP DEFICIENCY)	BE COMPLETION
	Water-Based Fire P 2011 Edition, Section owner or designated or repair deficiencies found during the instruction of the personnel or a quality requires records shattests, and maintenary and shall be made a having jurisdiction practice could affect visitors in the facility. Findings include: Based on record reventitled "Quarterly System Inspection" 07/21/22, 10/12/22, record review with the following was in a) In the deficiencies aforementioned inspinameplate - FAIL "missing." b) In the deficiencies aforementioned inspinameplate and interview the DOM stated that documentation shown ameplate or the replaced as of the time. During the exit contribution of the policy of the polic	rotection Systems. NFPA 25, on 4.1.4.1 states the property disconsistent and maintenance spection, test and maintenance fied contractor. NFPA 25, 4.3.1 and be made for all inspections, and of the system components vailable to the authority appon request. This deficient that all residents, staff, and the disconsistent of the system components was always. The Water Based Fire Protection documentation dated 01/11/23, and 04/21/23 during the Director of Maintenance a.m. to 11:35 a.m. on 07/05/23, oticed: as area of all four precions stated, "Hydraulic The Hydraulic nameplate is area of all four precions stated, "Recalled scattered throughout the at the time of record review, the could not provide any wing that the hydraulic called sprinklers had been		complete needed tasks for replacement of name plate. 2. Other side of sprinkle he system, hydraulic name plat place. 3. After name plate replace contracting agency, mainter will review inspection paper annually to ensure successing by contracted comp. Company also sent contract continue replacement of recipion sprinkler heads, as one side facility has been replaced. 4. Administrator will provide updates to the QAPI commi quarterly until all sprinkler have been replaced and naplate has been properly place.	ad te in d by nance work ful bany. t to called e of ttee eads me

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

PRINTED: 07/28/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 07/05/2023
155676 B. WING	07/05/2023
NAME OF PROVIDER OR SUPPLIER MILNER COMMUNITY HEALTH CARE STREET ADDRESS, CITY, STATE, ZIP COD 370 E MAIN ST ROSSVILLE, IN 46065	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY)	DATE
additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)	

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