STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING		X3) DATE SURVEY COMPLETED				
		155233	B. WING 02/25/2025					
	PROVIDER OR SUPPLIER		958 E	STREET ADDRESS, CITY, STATE, ZIP COD 958 E HWY 46 BATESVILLE, IN 47006				
(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	COMPLETION			
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE			
E 0000								
Bldg		paredness Survey was	E 0000	DISCLAIMER STATEMENT:				
	_	diana Department of Health in		Preparation and/or execution	n			
	accordance with 42 Survey Date: 02/25			of this plan of correction in general, or this corrective action, does not constitute a				
	Facility Number: 0			admission or agreement by facility of the facts alleged o				
	Provider Number:			conclusions set forth in this				
	AIM Number: 100	266500		statement of deficiencies. T plan of correction and speci-	-			
	At this Emergency	Preparedness survey, The		corrective actions are prepar				
	Waters of Batesville	e was found in compliance		and/or executed in complian	ce			
		eparedness Requirements for		with state and federal laws.				
		caid Participating Providers		This plan of correction				
	and Suppliers, 42 C	FR 483.73.		constitutes a written allegati				
	The facility has 86 of the survey, the cens	certified beds. At the time of ous was 56.		of substantial compliance wind Federal Medicare and Medicaid requirements.	ith			
	Quality Review con	mpleted on 02/28/25						
K 0000								
Bldg. 01								
-	A Life Safety Code	Recertification and State	K 0000	DISCLAIMER STATEMENT:				
	•	vas conducted by the Indiana		Preparation and/or execution	n			
	•	th in accordance with 42 CFR		of this plan of correction in				
	483.90(a).			general, or this corrective				
	Survey Date: 02/25	5/25		action, does not constitute a admission or agreement by f facility of the facts alleged o	this			
	Facility Number: 0	00138		conclusions set forth in this				
	Provider Number:			statement of deficiencies. T				
	AIM Number: 100	266500		plan of correction and speci- corrective actions are prepa				
	At this Life Safety	Code survey, The Waters of		and/or executed in complian				
	-	d not in compliance with		with state and federal laws.				
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SI	 GNATURE	TITLE	(X6) DATE			

(X6) DATE

Jalena Ball Administrator 03/12/2025

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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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155233		A. BUILDING 01 COMPLETED B. WING 02/25/2025			ETED		
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE, THE		STREET ADDRESS, CITY, STATE, ZIP COD 958 E HWY 46 BATESVILLE, IN 47006					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PR	ID ŒFIX ΓAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
	Life Safety from Fir National Fire Protec Life Safety Code (L Health Care Occupa This one story facili Type V (111) constr The facility has a fir detection in the corr	the 2012 edition of the edition Association (NFPA) 101, SC), Chapter 19, Existing encies and 410 IAC 16.2. The was determined to be of equation and fully sprinkled. The ealarm system with smoke editors, spaces open to the			This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.		
	detectors in all resid facility has a capaci 56 at the time of this All areas where resi were sprinkled and	dents have customary access all areas providing facility cled except the two story ce/laundry building.					
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Based on observation failed to install exit in accordance with 1 other than main exte and clearly are identificated by an approfrom any direction of states horizontal continuation of the continuation of the continuation of the continuation.	on and interview; the facility signage in 1 of 1 corridor exits LSC 7.10. LSC 7.10.1.2.1 exits, erior exit doors that obviously tifiable as exits, shall be ved sign that is readily visible of exit access. LSC 7.10.1.2.2 mponents of the egress path sure shall be marked by ectional exit signs where the egress path is not obvious. ce could affect up to 20	K 029	3	K293— It is the intent of the facto ensure to install exit signage corridor exits in accordance with LSC 7.10 to meet set standard 1 CORRECTIVE ACTIONS TAKEN: a OnMarch 6, 2025the Maintenance Supervisor/designee installed directional signage at the exit resident room #49 to meet set standards. The Administrator verified the work on Ma 6, 2025	e in th ls.	03/11/2025

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155233		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/25/2025	
	OF PROVIDER OR SUPPLIEI		958 E	ADDRESS, CITY, STATE, ZIP COD HWY 46 SVILLE, IN 47006	
	SUMMARY (EACH DEFICIENT REGULATORY OF Findings include: Based on observation between 2:30 p.m. the facility with the Maintenance Direct room # 49 lacked of the facility. The after options when exiting directional signage was the desired patt way. One choice leterminates at an entifacility. The Maintenance of the two paths is the signal of the signal o	THE STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION Ons and interview on 02/25/25 and 4:45 p.m. during a tour of Administrator (AD) and tor (MD), exit near resident irectional signage once exiting orementioned exit discharge had ag (right or left). There was no present to indicate which path th to a parking lot or the public ads around the building and trance door back into the enance Director agreed that the directional signage as only one part of the exit discharge. Eknowledged by the AD and discovery and again at the exit	958 E	HWY 46	ED: f to ENT 6, or nage neet dor nce ssed ne gnee
				4 MONITORING CORRECTIVE ACTION: a The inspection results w be presented by the Maintena Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the month	nce
				Quality Assurance/Performan	· •

AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155233		· /	JILDING	onstruction 01	(X3) DATE : COMPL 02/25 /	ETED	
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE, THE			STREET ADDRESS, CITY, STATE, ZIP COD 958 E HWY 46 BATESVILLE, IN 47006				
(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)	ΤE	(X5) COMPLETION DATE
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas Based on observation failed to ensure 1 of such as storage room properly working sedeficient practice corresidents, as well as Findings include: Based on observation between 2:30 p.m. a the facility with the	- Enclosure on and interview, the facility fover 10 hazardous area doors, ns, were provided with lf-closing devices. This ould affect more than 2 staff and visitors. ons and interview on 02/25/25 and 4:45 p.m. during a tour of Administrator (AD) and	K 0.		Improvement (QA/PI) meeting Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is	oy n s sility rs,	03/11/2025
	across from resident 50 square feet conta items, such as 16 lan wooden pallet. The room did not self-cl- frame. The AD state	or (MD), the shower room room number 12, greater than ined a number of combustible rge cardboard boxes and a corridor door to this shower ose and latch into the door ad that the shower room will out and it is not normally used			combustible items including cardboard boxes and a woode pallet from the shower room located across from resident ronumber 12 to meet set standa. The Administrator verified the on March 6, 2025 2 ALL OTHERS WITH	oom rds. work	

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155233	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 02/25/2025
	ROVIDER OR SUPPLIER		958 E	ADDRESS, CITY, STATE, ZIP COD HWY 46 SVILLE, IN 47006	
(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)	5.112
TAG	This finding was ac	knowledged by the AD and liscovery and again at the exit	TAG	POTENTIAL TO BE AFFECT a All residents and all star and visitors have the potential be affected but none were. 3 MEASURES TO PREVENCE: a On March 2025 the Administratinserviced the Maintenance Supervisor/designee and all son the requirement to ensure hazardous areas are equipped with a self-closing door to me set standards. b Maintenance Supervisor/designee will ensure hazardous areas are equipped with a self-closing door as a pof the facility's monthly Preventance Program and document those inspection reas appropriate. If any issues discovered, they will be address and resolved immediately. The Maintenance Supervisor/designee will ensure the inspection results. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4 MONITORING CORRECTIVE ACTION: a The inspection results were be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Adminis	ED: If all to ENT 6, ator Staff ed et Ure ed coart entive essults s are essed he gnee ator vill ance
i l			I	Administrator will present the	1

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155233		A. BUILDING <u>01</u> COM		COMPLETED 02/25/2025		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 958 E HWY 46 BATESVILLE, IN 47006			
(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)	DATE	
K 0363 SS=E Bldg. 01	failed to ensure 1 of was provided with a the door closed, had latching and would a This deficient practic. Findings include: Based on observation between 2:30 p.m. a the facility with the Maintenance Direct the Therapy Room weight. Based on in observation, the MD aforementioned corrunless the weight was	on and interview, the facility 1 therapy room corridor doors 2 means suitable for keeping 2 no impediment to closing, 3 resist the passage of smoke. 3 ce could affect 6 residents. 3 and interview on 02/25/25 3 and 4:45 p.m. during a tour of 4 Administrator (AD) and 4 or (MD) the corridor door to 4 was propped open with a 5 terview at the time of 6 acknowledged the 6 cidor door would not close 6 as moved first. No residents 6 the therapy area at the time of	K 0363	inspection results at the month Quality Assurance/Performand Improvement (QA/PI) meeting Inspection results and system components will be reviewed the QA/PI Committee with subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is03/11/2025 K363 – It is the intent of the facility to ensure corridor doors provided with a means suitable keeping the doors closed, having meeting and will resist the passage of smoke to meet set standards. 1 CORRECTIVE ACTIONS TAKEN: a On March 12025 the Maintenance Supervisor/designee removed weight that was propping the copen to the therapy room to meet set standards. The Administrative rified the repair on March 11, 2025 2 ALL OTHERS WITH	obe oby ns oby ns obs obs obs obs obs obs obs	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		ì í	ULTIPLE CO	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED		
		155233		B. WING 02/25/202			
	PROVIDER OR SUPPLIE		•	958 E H	ADDRESS, CITY, STATE, ZIP COD HWY 46 VILLE, IN 47006		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
	observation.				POTENTIAL TO BE AFFECT	ED:	
					a All residents and all stat	ff	
		cknowledged by the AD and			and visitors have the potentia	l to	
		discovery and again at the exit			be affected but none were. T		
	conference with ea	ich present.			Maintenance Supervisor/desi	-	
	2.1.10(1)				inspected all doors and found	l no	
	3.1-19(b)				other negative findings.		
					3 MEASURES TO PREVE REOCCURRENCE:	EN I	
					a On March 11, 202	15	
					the Administrator in	.5	
					serviced the Maintenance		
					Supervisor/All staff on the		
					requirement to ensure corrido	or	
					doors have no impediments to		
					closing and latching to meet s		
					standards.		
					b Maintenance		
					Supervisor/designee will insp	ect	
					all doors throughout the facilit	-	
					monthly to ensure corridor do		
					close and latch into the frame		
					part of the facility's Preventive	е	
					Maintenance Program and		
					document those inspection re		
					as appropriate. If any issues		
					discovered, they will be addre and resolved immediately. The		
					Maintenance Supervisor/desi		
					will review with the Administra	•	
					the inspection results.		
					c The Administrator will		
					monitor adherence to the		
					Preventative Maintenance		
					schedule and validate the		
					Preventative Maintenance		
					documentation is in place.		
					4 MONITORING		
					CORRECTIVE ACTION:		
					a The inspection results v	vill	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		ľ í	ULTIPLE CO	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED	
ANDILAN	or connection	155233				02/25/2025
	PROVIDER OR SUPPLIE			958 E F	ADDRESS, CITY, STATE, ZIP COD HWY 46 VILLE, IN 47006	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY 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)	(X5) COMPLETION DATE
		R ESC IDENTITY THAT IN ORMANION		TAG .	be presented by the Maintena Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the month Quality Assurance/Performand Improvement (QA/PI) meeting Inspection results and system components will be reviewed the QA/PI Committee with subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is March 11, 2025	hly ce g. by
K 0921 SS=F Bldg. 01	interview, the facil required maintenan documentation of in Related Electrical 2012 edition, section physical integrity, touch current tests is performed as recommendate are established with PCREE used in paraccordance with 10 into service and affirmation of the facility of the facilit	eview, observation, and ity failed to conduct the nee and maintain complete inspections for Patient Care Equipment (PCREE). NFPA 99 cons 10.3 and 10.5 states the resistance, leakage current, and for fixed and portable PCREE quired in 10.3. Testing intervals the policies and protocols. All tient care rooms is tested in 0.3.5.4 or 10.3.6 before being put ter any repair or modification. ting of several electrical	K 09	921	K921 – It is the intent of the facility to ensure to conduct the required maintenance and maintain complete documents of inspections for Patient Care Related Electrical Equipment (PCREE) to meet set standard 1.CORRECTIVE ACTIONS TAKEN: 1.OnMarch 06, 20 the facilities trained Regional Property Manager we conduct PCREE testing on the other PCREE in the facility	ation e ds. 025

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STATEMENT OF DEFICIENCIES 2		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> C			COMPL	ETED
155233		B. WING 02/25/2025			2025		
		<u> </u>		CTDEET A	ADDRESS, CITY, STATE, ZIP COD	I	
NAME OF F	PROVIDER OR SUPPLIER	8		958 E H			
\\\\\\	OE DATES////	TUE					
WATERS	OF BATESVILLE,	INC		DATES	VILLE, IN 47006		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	<u> </u>	TAG	DEFICIENCY)		DATE
		rates compliance with NFPA			including: electric beds,		
		stem. Service manuals,			nebulizers, oxygen concentrat	tors,	
	_	ocedures provided by the			vital sign monitors, and other		
		de information as required by			electrical medical equipment t	o	
		considered in the development			meet set standards. The		
		ectrical equipment maintenance.			Administrator verified the work	c on	
		nt instructions and maintenance			March 06,	,	
	I -	available, and safety labels			2025		
		rating instructions on the			2.ALL OTHERS WITH		
		e. A record of electrical			POTENTIAL TO BE AFFECTE	ED:	
	equipment tests, rep	pairs, and modifications is			1.All residents and all sta	ıff	
	maintained for a per	riod of time to demonstrate			and visitors have the potential	to	
	compliance in accor	rdance with the facility's			be affected but none were.		
	policy. Personnel re	esponsible for the testing,			3.MEASURES TO PREVEN	т	
	maintenance and us	se of electrical appliances			REOCCURRENCE:		
	receive continuous	training. This deficient			1.OnMarch 06, 20	25	
	practice affects all r	residents.			the Administrator		
					inserviced the Maintenance		
	Findings include:				Supervisor/designee to ensure	e the	
					testing of the PCREE is		
	Based on records re	eview, interview and facility			conducted and documented o	n all	
	tour with the Admir	nistrator (AD) and	PCREE equipment to meet set				
	Maintenance Direct	tor (MD) on 02/25/25 between			standards.		
	10:30 a.m. and 4:45	p.m., no documentation was			2.Maintenance		
	available for review	for the testing of the PCREE in			Supervisor/designee will ensu	re	
	_	facility, as required by section			testing of the PCREE is		
		9, Health Care Facilities Code.			conducted and documented o	n all	
	Observation during	the building tour revealed that			PCREE equipment as a part o	of the	
		d electric beds for all residents.			facility's annual Preventive		
	The AD stated that	PCREE such as nebulizers,			Maintenance Program and		
	oxygen concentrato	rs, vital signs monitors, and			document those inspection res	sults	
		lical equipment was present			as appropriate. If any issues	are	
	and in use at the facility.				discovered, they will be addre	ssed	
		ID stated that the facility was			and resolved immediately. Th	ne l	
	not aware that the P	PCREE was required to be			Maintenance Supervisor/desig	gnee	
	tested.				will review with the Administra	tor	
					the inspection results.		
	This finding was ac	knowledged by the AD and			3.The Administrator will		
	MD at the time of d	liscovery and again at the exit			monitor adherence to the		
	conference with each	conference with each present.			Preventative Maintenance		

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155233	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 02/25/2025	
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE, THE		STREET ADDRESS, CITY, STATE, ZIP COD 958 E HWY 46 BATESVILLE, IN 47006					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) schedule and validate the	ATE	(X5) COMPLETION DATE	
	3.1-19(b)			Preventative Maintenance documentation is in place. 4.MONITORING CORRECT ACTION: 1.The inspection results be presented by the Maintena Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the mont Quality Assurance/Performan Improvement (QA/PI) meeting Inspection results and system components will be reviewed the QA/PI Committee with subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is	will ance hly ce j. by n as		

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