PRINTED: 09/19/2017 FORM APPROVED OMB NO. 0938-0391

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	01	COMPL	ETED	
		155441	B. W	NG		08/29/2017		
			STREET A	ADDRESS, CITY, STATE, ZIP CODE				
NAME OF P	ROVIDER OR SUPPLIER				UNTRY CLUB RD			
CORYDO	RYDON NURSING AND REHABILITATION CENTER				OON, IN 47112			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE	
K 0000								
Bldg. 01								
Blug. 01	A Life Cafety Ca	de Descriffestion and	K 0	000			ı	
		ode Recertification and	KU	000				
		Survey was conducted by						
		Department of Health in						
	accordance with	42 CFR 483.70(a).						
	Survey Date: 08	3/29/17						
	3							
	Facility Number: 000338							
Provider Number: 155441								
	AIM Number: 100287590							
	At this Life Safe	ty Code survey, Corydon						
	_	abilitation Center was						
		tial compliance with						
	Requirements for	•						
		aid, 42 CFR Subpart						
	483.70(a), Life S	Safety from Fire and the						
	2012 edition of t	he National Fire						
	Protection Assoc	ciation (NFPA) 101, Life						
		C), Chapter 19, Existing						
	- '	upancies and 410 IAC						
	16.2.	upaneles and 410 I/1C						
	10.4.							
	This one story fo	aility was datarmined to						
		icility was determined to						
	31	1) construction and was						
		. The facility has a fire						
	•	th hard wired smoke						
	detectors in the c	corridors and spaces open						
	to the corridors,	plus battery operated						
		all resident sleeping						
		lity has a capacity of 38						
	1301115. 1110 111011	ing into a supasity of 50						

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

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>01</u>		COMPLETED		
		155441	B. WING		08/29/2017		
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		315 CO	ADDRESS, CITY, STATE, ZIP CODE UNTRY CLUB RD OON, IN 47112		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		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 APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	survey.	s of 22 at the time of this					
		residents have customary					
	-	nklered and all areas					
	providing facility						
	sprinklered, exce	ept two detached sheds					
	used for facility	storage.					
	Quality Review DA	completed on 08/29/17 -					
K 0347 SS=C Bldg. 01	spaces open to co 19.3.6.1. 19.3.4.5.2 Based on record observation; the documentation for maintenance of 2 smoke alarms in laundry and at the complete for 2 o NFPA 101 in 4.6 safety features of not required by to maintained. This affect all resident	:	K 0:	347	Preparation and /or execution this plan does not constitute admission or agreement by the provider of the truth of the fact alleged or conclusions set forth on the statement of deficiencie. This plan of correction is prepared and/or executed sole because required. K 347 Smoke Detection What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice; O Although there was not an	e s n es.	09/12/2017
	Based on review	of the "Battery Check			itemized location list available to		

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Event ID:

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	OF CORRECTION	IDENTIFICATION NUMBER: 155441		JILDING	<u>01</u>	COMPL 08/29/	ETED
	ROVIDER OR SUPPLIER	REHABILITATION CENTER	•	315 CO	ADDRESS, CITY, STATE, ZIP CODE OUNTRY CLUB RD OON, IN 47112		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	CATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) "reports on 08/29/17 at		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) track facility was monitoring all	ΓE	(X5) COMPLETION DATE
IAG	Smoke Detectors 11:15 a.m. with the present, there was resident room, last station battery optested for function July of 2017. The available for June monthly TELS resident comples did not identify I alarm tested and with each smoke interview at the the Maintenance started using the and there was not to show the test relist of battery open The Maintenance were no problem operated smoke a and July testing probservations between 1:45 p.m. during	"reports on 08/29/17 at he Maintenance Director's no itemized list of undry, and nurses' perated smoke alarms nality during June and e only documentation e and July of 2017 was a eport indicating the task ted. The TELS report ocation of each smoke if there were any issues alarm. Based on ime of record review, Director said the facility TELS program recently place on the TELS form results for an itemized erated smoke alarms. The Director also said there is with any battery alarms during the June period. Based on ween 12:30 p.m. and a tour of the facility		IAG	track, facility was monitoring all smoke detectors via TELs O Going forward facility will use an itemized location list log. - How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; O Although there was not an itemized location list available to track, facility was monitoring all smoke detectors via TELs O Going forward facility will use an itemized location list log. - What measures will be into place or what systemic changes will be made to ensure that the deficient practice does not occur; O Have put into place a monthly itemized location list log. O Maintenance Director will be educated and In-serviced on 9/12/17 - How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e.,	t	DATE
	operated smoke a	ance Director, battery alarms were observed in ing rooms, the laundry station.			what quality assurance program will be put into place O Administrator/designee will review itemized location log monthly for six months until compliance is maintained for two		
	3.1-17(0)				consecutive quarters. O The results of these audits will b reviewed by the QAPI committee monthly. If compliance is not	e	

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	OF CORRECTION	IDENTIFICATION NUMBER: 155441	A. BUILDING B. WING	01	COMPLETED 08/29/2017
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	315 CC	ADDRESS, CITY, STATE, ZIP CODE DUNTRY CLUB RD DON, IN 47112	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B: CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) E COMPLETION DATE
K 0353 SS=C Bldg. 01	Sprinkler System - Automatic sprinkler are inspected, test accordance with N Inspection, Testing Water-based Fire Records of system inspection and test secure location and a) Date sprinkler b) Who provided c) Water system Provide in REMAR coverage for any rautomatic sprinkle 9.7.5, 9.7.7, 9.7.8, Based on record interview; the fact sprinkler system accordance with	supply source RKS information on non-required or partial or system. and NFPA 25 review, observation and cility failed to document	K 0353	achieved, an action plan will be developed and implemented. Monthly QAPI minutes and action plans are submitted to regional operations staff and corporate ris management team for review. - By what date the systemic changes will be completed O 9/28/17 - Facility requests desk revin lieu of revisit Preparation and /or execution this plan does not constitute admission or agreement by provider of the truth of the facility alleged or conclusions set for on the statement of deficience.	iew on of 09/12/2017 the licts orth

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	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER: 155441		l í	JILDING	onstruction 01	(X3) DATE S COMPLI 08/29/2	ETED
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	•	315 CO	ADDRESS, CITY, STATE, ZIP CODE UNTRY CLUB RD OON, IN 47112	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	of Water-Based 2011 Edition, Se gauges on wet sp inspected month in good conditions supply pressure Section 5.1.2 state department conninspected, tested	resting, and Maintenance Fire Protection Systems, action 5.2.4.1 states orinkler systems shall be ly to ensure that they are and that normal water is being maintained. Ites valves and fire ections shall be and maintained in Chapter 13. Section			This plan of correction is prepared and/or executed sole because required. K 353 Sprinkler System – Maintenance and Testing - What corrective action (s) will be accomplished for those	ely	
1	13.1.1.2 states T	able 13.1.1.2 shall be action, testing and			residents found to have been affected by the deficient practice;		
	maintenance of vand trim. Section shall be made for any maintenance components and to the authority by request. This de	valves, valve components in 4.3.1 states records in all inspections, tests, so of the system and its shall be made available maving jurisdiction upon ficient practice could its, staff, and visitors in			O Although there was not sprinkle system gauge and system control valve inspection documentation, facility was doing a monthly visual test. O Going forward facility will use a sprinkler system gauge and system control valve inspection log	ir	
	11:47 a.m. with a present, there was available from S sprinkler inspect 09/06/16, 12/13/06/29/17. Month gauge inspection	review on 08/29/17 at the Maintenance Director as documentation afe Care that quarterly ions were performed on 16, 03/18/17, and haly wet sprinkler system a documentation for 8 ost recent 12 month			- How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be take; O Although there was not sprinkle system gauge and system control valve inspection documentation, facility was doing a monthly visual test.		

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NAME OF PROVIDER OR SUPPLIER CORYDON NURSING AND REHABILITATION CENTER (X-1) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY TULL TAG REGULATORY OR LES CENTERINGE SPORMATION) PETER (EACH DEFICIENCY MUST BE PRECEDED BY TULL AGdition, monthly inspection documentation for all sprinkler system control valves for 8 months of the most recent 12 month period was also not available for review, the Maintenance Director indicated the facility performs regular visual sprinkler system inspections but does not documentation for the aforementioned monthly periods was not available for review. Based on observation with the Maintenance Director during a tour of the facility at 12:30 p.m. the facility has two wet pressure gauges at the sprinkler riser. 3.1-19(b) SIRBIT ADDRESS CITY, STATL 2/P CODE 315 COUNTRY CLUB RD CORYDON, IN 47112 ID PRETEX TAG TO CORRECTOR CASE PREFERENCE TO THE APPROPAGATE CONTROL AND TAG TAG TO THE APPROPAGATE CONTROL AND TAG		OF CORRECTION	IDENTIFICATION NUMBER: 155441	ľ í	JILDING	<u>01</u>	COMPL 08/29/	ETED
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) period was not available for review. In addition, monthly inspection documentation for all sprinkler system control valves for 8 months of the most recent 12 month period was also not available for review, Based on interview at the time of record review, the Maintenance Director indicated the facility performs regular visual sprinkler system inspections but does not document sprinkler system gauge and system control valves inspections and acknowledged sprinkler system gauge and system gauge and control valve inspection documentation for the afforementioned monthly periods was not available for review. Based on observation with the Maintenance Director during a tour of the facility at 12:30 p.m. the facility has two wet pressure gauges at the sprinkler riser. 3.1-19(b) PREFIX TAG O Going forward facility will use a sprinkler system gauge and system control valve inspection log O Admintenance Director director will use log monthly to track O Maintenance Director will be educated and in-serviced on 9/12/17 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place O Administrator/designee will review sprinkler system gauge and system control valve inspection log monthly for six months until compliance is maintained for two consecutive quarters.			REHABILITATION CENTER		315 CO	UNTRY CLUB RD		
addition, monthly inspection documentation for all sprinkler system control valves for 8 months of the most recent 12 month period was also not available for review. Based on interview at the time of record review, the Maintenance Director indicated the facility performs regular visual sprinkler system inspections but does not document sprinkler system gauge and system control valves inspections and acknowledged sprinkler system gauge and control valve inspection documentation for the aforementioned monthly periods was not available for review. Based on observation with the Maintenance Director during a tour of the facility at 12:30 p.m. the facility has two wet pressure gauges at the sprinkler riser. 3.1-19(b) sprinkler system gauge and system control valve inspection log A Monthly Sprinkler Riser Inspection Log was put into place O Maintenance Director will use log monthly to track O Maintenance Director will be educated and In-serviced on 9/12/17 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place O Administrator/designee will review sprinkler system gauge and system control valve inspection log monthly for six months until compliance is maintained for two consecutive quarters.	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	COMPLETION
reviewed by the QAPI committee monthly. If compliance is not achieved, an action plan will be developed and implemented. Monthly QAPI minutes and action	TAG	period was not an addition, monthly documentation for control valves for recent 12 month available for reviat the time of recommentation for activity performs system inspection document sprink system control variation for acknowledged sprand control valved documentation for monthly periods review. Based of Maintenance Dir facility at 12:30 pwet pressure gau	vailable for review. In y inspection or all sprinkler system or 8 months of the most period was also not ew. Based on interview ord review, the ector indicated the regular visual sprinkler ins but does not ler system gauge and alves inspections and orinkler system gauge e inspection or the aforementioned was not available for in observation with the ector during a tour of the facility has two		TAG	O Going forward facility will use a sprinkler system gauge and system control valve inspection log - What measures will be into place or what systemic changes will be made to ensure that the deficient practice does not occur; O A Monthly Sprinkler Riser Inspection Log was put into place O Maintenance Director will use lo monthly to track O Maintenance Director will be educated and In-serviced on 9/12/17 - How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place O Administrator/designee will review sprinkler system gauge and system control valve inspection log monthly for six months until compliance is maintained for two consecutive quarters. O The results of these audits will be reviewed by the QAPI committee monthly. If compliance is not achieved, an action plan will be developed and implemented.	t g	DATE

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING <u>01</u>			COMPLETED			
		155441	B. WI	· · · · · · · · · · · · · · · · · · ·			08/29/2017	
			STREET ADDRESS, CITY, STATE, ZIP CODE					
NAME OF P	ROVIDER OR SUPPLIER							
CORVEC		DELIABILITATION CENTED			UNTRY CLUB RD			
CORYDO	ORYDON NURSING AND REHABILITATION CENTER			CORYL	OON, IN 47112			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		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	ΓE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
					plans are submitted to regional			
					operations staff and corporate risk			
					management team for review.			
					- By what date the systemic			
					changes will be completed			
					0 0/20/17			
					O 9/28/17			
					 Facility requests desk review 	v		
					in lieu of revisit	•		
					in nea of revisit			
K 0712	NFPA 101							
SS=C	Fire Drills							
Bldg. 01	Fire Drills							
		the transmission of a fire						
	•	simulation of emergency						
	fire conditions. Fire							
		under varying conditions, on each shift. The staff is						
	•	dures and is aware that						
	drills are part of es							
		planning and conducting						
		only to competent persons						
		to exercise leadership.						
	•	onducted between 9:00						
	PM and 6:00 AM, a coded announcement							
	may be used inste	ad of audible alarms.						
		8.7.1.7, 19.7.1.4 through						
	19.7.1.7							
	Based on record	review and interview,	K 0'	712	Preparation and /or execution	of	09/12/2017	
	the facility failed	l to ensure fire drills			this plan does not constitute	_		
	were held at vari	ed times for 2 of 3			admission or agreement by the provider of the truth of the fact			
		during 4 of 4 quarters.			alleged or conclusions set forth			
	chipio y co sinitis	daring i or i quartors.			on the statement of deficiencie			
					2 the statement of denoiching	, J.		

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STATEMEN	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING <u>01</u>		COMPL	ETED
		155441	B. W	ING		08/29/2017	
				CTREET	ADDRESS SITE STATE SID CODE		
NAME OF P	ROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP CODE		
000,00		DELLARU ITATIONI OFNITED			OUNTRY CLUB RD		
CORYDO	ON NURSING AND	REHABILITATION CENTER		CORYL	OON, IN 47112		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	12	DATE
	This deficient pr	ractice could affect all			This plan of correction is		
	patients in the fa				prepared and/or executed sole	∍ly	
	patients in the la	emty.			because required.		
	Findings include	2.					
	Based on review	of the facility's fire drills			K 712 Fire Drills		
		0:42 a.m. with the					
		rector present, the					
	following was n	_			NAMES AS ASSESSED AS ASSESSEDANCE AS ASSESSED AS ASSESSED AS ASSESSED AS ASSESSED AS ASSESSEDANCE AS ASSESSED AS ASSESSED AS ASSESSED AS ASSESSED AS ASSESSEDANCE AS ASSESSED AS ASSESSED AS ASSESSED AS ASSESSED AS ASSESSEDANCE AS ASSESSEDA		
	•				- What corrective action (s)		
		first shift (day) fire drills			will be accomplished for those		
	were performed between 9:30 a.m. and				residents found to have been		
	10:30 a.m.				affected by the deficient practice;		
	b. Three of four	, second shift (evening)			O Fire Drille will be completed at		
		performed between 7:50			O Fire Drills will be completed at varied times for all shifts		
	p.m. and 8:25 p.				varied times for all silits		
	-						
	_	riew at the time of record					
	review, the Main	ntenance Director			- How other residents having	,	
	acknowledged th	ne times the first and			the potential to be affected by the	,	
	second shift fire	drills were performed			same deficient practice will be		
		imes were not varied			identified and what corrective		
	enough.				action(s) will be taken;		
	onougn.						
	2.1.10(1)				O Fire drills will be completed at		
	3.1-19(b)				varied times on all shifts		
					- What measures will be into	,	
					place or what systemic changes will		
					be made to ensure that the deficien	it	
					practice does not occur;		
					O Fire drills will be completed at		
					varied times on all shifts		
	1		1		l		1

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	OF CORRECTION	IDENTIFICATION NUMBER: 155441	A. BUILDING B. WING	01	COMPLETED 08/29/2017
	ROVIDER OR SUPPLIER	REHABILITATION CENTER	315 CC	ADDRESS, CITY, STATE, ZIP CODE DUNTRY CLUB RD DON, IN 47112	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
				O Maintenance Director will be educated and In-serviced on 9/12/17	
				- How the corrective action will be monitored to ensure the deficient practice will not recur, i.w. what quality assurance program when be put into place O Administrator will review monin QA MEETINGS that first and second shift fire drills are varied. Administrator/designee will review Fire Drill log monthly for six month until compliance is maintained for	e., vill w hs
				two consecutive quarters. O The results of these audits will reviewed by the QAPI committee monthly. If compliance is not achieved, an action plan will be developed and implemented. Monthly QAPI minutes and action plans are submitted to regional operations staff and corporate risk management team for review.	
				- By what date the systemic changes will be completed O 9/28/17	c

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCT			ONSTRUCTION	(X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING 01			COMPLETED	
155441			B. WING			08/29/2017		
	NAME OF PROVIDER OR SUPPLIER CORYDON NURSING AND REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			315 CO	ADDRESS, CITY, STATE, ZIP CODE DUNTRY CLUB RD DON, IN 47112			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		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	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
					- Facility requests desk reviewin lieu of revisit	w		

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