PRINTED: 08/31/2022 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED 08/04/2022	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155354	A. BUILDING B. WING	00		
	PROVIDER OR SUPPLIE		10466 F	ADDRESS, CITY, STATE, ZIP COD POLLACK AVE JRGH, IN 47630		
NEWBUI	KGH HEALTH CAR	<u> </u>	INEVVB	JRGH, IN 47030		
(X4) ID PREFIX	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		
TAG	REGULATORY O	OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY	DATE	
F 0000 Bldg. 00	This visit was for t	the Investigation of Complaint	F 0000			
	_	35996: Substantiated. iencies related to the ed at F0623.		Preparation and or execution of this plan of Correction general or any other corrective action set forth herein,		
	Survey dates: Aug Facility number: 0 Provider number: AIM number: 1002 Census bed type: SNF/NF: 55 Total: 55 Census payor type Medicare: 6	00245 155354 290800		in particular, does not constitute an admission or agreement by Newburgh Healthcare of the facts allege the conclusions set forth in the Statement of Deficiencies. The Plan of Correction and specific corrective actions are prepared and / or executed solely becau of provisions of Federal and / or State law.	d or	
F 0623	accordance with 4 Quality review cor 483.15(c)(3)-(6)(4	mpleted on August 9, 2022.				
SS=D Bldg. 00	Notice Requirem Transfer/Dischard §483.15(c)(3) No Before a facility to resident, the facil	ents Before ge tice before transfer. ransfers or discharges a				

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

representative(s) of the transfer or discharge and the reasons for the move in writing and in

TITLE

(X6) DATE

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00		(X3) DATE SURVEY COMPLETED	
		155354	B. WING		08/04/	2022
	PROVIDER OR SUPPLIER		10466 F	ADDRESS, CITY, STATE, ZIP COD POLLACK AVE JRGH, IN 47630		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	· 		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	facility must send representative of the Long-Term Care (ii) Record the readischarge in the reaccordance with procession; and (iii) Include in the reaccordance with procession; and (iii) Include in the reaccordance with procession; and (iii) Include in the reaccordance with procession; and (c)(5) S483.15(c)(4) Tim (i) Except as spectand (c)(8) of this stransfer or discharsection must be made and the section must be made and the section must be practicable before (A) The safety of it would be endanged (i)(C) of this section (B) The health of it would be endanged (i)(D) of this section; (C) The resident's to allow a more important to al	sons for the transfer or esident's medical record in paragraph (c)(2) of this motice the items described of this section. Ing of the notice. Ing of the notice of the ingerequired under this pade by the facility at least the resident is transferred or the made as soon as transfer or discharge when-individuals in the facility ered under paragraph (c)(1) on; the alth improves sufficiently individuals in the facility ered, under paragraph (c)(1) on; the alth improves sufficiently individuals in the facility ered, under paragraph (c)(1)(i)(B) of this transfer or discharge is sident's urgent medical agraph (c)(1)(i)(A) of this intents of the notice. The				
	- ' ' ' '	cified in paragraph (c)(3) of				

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this section must include the following:

Event ID:

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STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X		X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155354	B. WING 08/04/2022				2022
				CTD FFT A	ADDRESS SITE OF STATE OF		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
NIEWDI IE	RGH HEALTH CAR	Г			POLLACK AVE		
NEWBUR	RGH HEALTH CAR	<u> </u>		NEWBC	JRGH, IN 47630		
(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
	` '	transfer or discharge;					
	(ii) The effective d	ate of transfer or discharge;					
	(iii) The location to	which the resident is					
	transferred or disc	charged;					
		f the resident's appeal					
		ne name, address (mailing					
	and email), and te	elephone number of the					
	-	ves such requests; and					
		w to obtain an appeal form					
		completing the form and					
		peal hearing request;					
	, ,	dress (mailing and email)					
	•	mber of the Office of the					
	_	Care Ombudsman;					
		cility residents with					
		evelopmental disabilities or					
		, the mailing and email					
		hone number of the agency					
	-	e protection and advocacy					
		developmental disabilities					
	established under						
		sabilities Assistance and					
	-	of 2000 (Pub. L. 106-402,					
		.C. 15001 et seq.); and					
		acility residents with a					
		r related disabilities, the					
	_	address and telephone					
	_	ency responsible for the					
	•	vocacy of individuals with a					
		stablished under the					
		vocacy for Mentally III					
	Individuals Act.						
	\$402 15(a)(6) Cha	anges to the notice					
	- ' ' ' '	anges to the notice.					
		in the notice changes prior					
	_	insfer or discharge, the					
		te the recipients of the practicable once the					
		•					
	upuateu miomialio	on becomes available.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155354		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 08/04/2022				
	PROVIDER OR SUPPLIER		10466	STREET ADDRESS, CITY, STATE, ZIP COD 10466 POLLACK AVE NEWBURGH, IN 47630		
(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	
	closure In the case of facil who is the adminis provide written no impending closure Agency, the Office Care Ombudsmar and the resident re the plan for the tra relocation of the re 483.70(I). Based on interview failed to ensure a no supplied in writing representative for 2 hospitalizations. The the area ombudsmar transfer/discharges for hospitalizations. Resident D) Findings include: 1. During record rev an Admission/Discl Resident B was disc hospital on 7/6/22. Resident B's nurse's limited to, a progres alerted nurse that re Called [physician] from and called [family] [name of hospital]. sent with [resident In [diagnoses], allergic orders."	for 3 of 3 residents reviewed (Resident B, Resident C, view on 8/3/22 at 10:30 A.M., narge Report indicated charged to an acute care	F 0623	table class="Table TableStaticStyles Ltr TableWordWrap SCXW2065-BCX0" border="1" data-table data-tablelook="1696" aria-rowcount="1" >div > p class="Paragraph SCXW20654436 BCX0" xml:lang="EN-US" paraid="2005965285" paraeid="{0a05469a-33c1-4a 4f-a09f41a008a5}{24}" > p class="Paragraph SCXW20654436 BCX0" xml:lang="EN-US" paraid="886757352" paraeid="{fd354d7c-0da3-473 1-0abbd0e1fbbd}{155}" >- Wh corrective action(s) will be accomplished for those reside found to have been affected be deficient practice;	37-b7 3d-adf nat	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 00 COMPLETE			
		155354	B. WI	NG		08/04/	/2022
NAME OF I	DROWDER OF CURRINE		•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	C			POLLACK AVE		
NEWBU	RGH HEALTH CAR	E		NEWBU	JRGH, IN 47630		
(X4) ID		STATEMENT OF DEFICIENCIE		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	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		tor indicated the staff nurse ce of transfer/discharge with			The facility's Social Service Director has revised the proce		
	the resident at the ti	9			for notifying the	:55	
	the resident at the ti	me of discharge.			State Ombudsman of		
	No records indicate	d Resident B or Resident B's			Discharges/Transfers. The So	cial	
		ved a written notice of			Services director has submitte		
	transfer/discharge.				of Julys discharges/transfers.		
	During an interview	on 8/4/22 at 9:15 A.M., the					
	Social Service Dire	ctor indicated they were told					
	they no longer were				- How other residents having t	he	
		nformation to the area on			potential to be affected by the		
		resident discharge to the			same deficient practice will be	!	
	hospital.				identified and what corrective		
					action(s) will be taken;		
	_	view on 8/3/22 at 10:30 A.M.,					
		narge Report indicated					
		charged to an acute care			The facility to Conial Compies		
	hospital on 7/20/22.	•			The facility's Social Service		
	Pasident C's nurse's	s notes included, but were not			Director has revised the proce for notifying the	:55	
		ss note, dated 7/20/22,			State Ombudsman of		
		of condition change and [vital			Discharges/Transfers. The So	rial	
	_	ed he be sent to [Name of			Services director will submit a		
	Hospital]."				of August's discharges/transfe		
					the end of the month.	===	
	Hospital records inc	dicated Resident C arrived to					
	the Emergency Dep	partment on 7/20/22. On 7/21/22,					
	Resident C had been	n admitted to the hospital.					
					- What measures will be put ir		
		d Resident C or Resident C's			place and what systemic chan	iges	
	_	ved a written notice of			will be made to ensure that the		
	transfer/discharge.				deficient practice does not rec	ur;	
	During an interview	on 8/4/22 at 9:15 A.M., the					
	_	ctor indicated they were told					
	they no longer were				The facility's Social Service		
		nformation to the area on			Director has revised the proce	ess	
	_	resident discharge to the			for notifying the		
	hospital.	-			State Ombudsman of		

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155354		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/04/2022	
	PROVIDER OR SUPPLIER		10466	ADDRESS, CITY, STATE, ZIP COD POLLACK AVE BURGH, IN 47630	
(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)	DATE
	an Admission/Discl	view on 8/3/22 at 10:30 A.M., narge Report indicated charged to an acute care		Discharges/Transfers. The So Services director will submit a of the discharges/transfer at t end of the month, each month	all he
	admitted to the hosp 7/22/22. During an interview Social Service Directhey no longer were transfer/discharge in	dicated Resident D was pital on 7/6/22 and discharged on 8/4/22 at 9:15 A.M., the etor indicated they were told required to send information to the area on esident discharge to the		- How the corrective action(s) be monitored to ensure the deficient practice will not recui.e., what quality assurance program will be put into place and	ır,
	State Ombudsman provider letter dated providers to notify the and the local Ombutransfer on a month	provided a copy of the d April 8, 2021 instructed the state LTC Ombudsman dsman of the acute emergency ly bases. ates to Complaint IN00385996.		The facility's Social Service Director has revised the proof for notifying the State Ombudsman of Discharges/Transfers. The So Services director will submit a of the discharges/transfer at t end of the month, each month The Social Services Director bring the binder of "Notice of Discharge/Transfer to Ombudsman" to the monthly meetings for the next 5 month and as needed thereafter.	ocial all he n. will
				- by what date the systemic changes for each deficiency to be completed.	will
				9/1/2022	

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155354	B. WI	NG	08/04/		/2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	R			POLLACK AVE		
NEWBU	RGH HEALTH CAR	F			JRGH, IN 47630		
TIE VIDOI				INEWBO	1		T
(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	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					VANIS AS A STATE OF THE STATE O	1 h a	
					- What corrective action(s) will		
					accomplished for those residents found to have been affected by the deficient practice;		
					delicient practice,		
					Nurses have been re-educate	d on	
					the requirements to provide a	u on	
					resident or resident's		
					representative with a bed hold	1	
					notice when a resident is	1	
					transferred to a hospital. Pack	ote.	
					have been assembled and pla		
					at each nurse's station to prov		
					nurses with easier access to t		
					Bed-hold policy and other requ		
					paperwork when		
					discharging/transferring reside	ents.	
					At the time of admission, facili		
					bed hold policy will be verbally	-	
					explained to resident's		
					representative and first notice	of	
					bed hold policy will be signed.		
					the time of actual transfer, the		
					resident/resident's representa		
					will be notified of bed hold poli		
					again. These forms will be ser	-	
					with the resident on transfer a		
					copy will be made to be kept i	n	
					the resident's medical record.		

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155354		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 08/04/2022	
	ROVIDER OR SUPPLIE		10466	ADDRESS, CITY, STATE, ZIP COD POLLACK AVE URGH, IN 47630	
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				- How other residents having potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;	e e
				Nurses have been re-educate the requirements to provide a resident or resident's representative with a bed hold notice when a resident is transferred to a hospital. Pack have been assembled and pla at each nurse's station to provinurses with easier access to bed-hold policy and other requirements bed hold policy and other requirements when discharging/transferring resident the time of admission, facily bed hold policy will be verbally explained to resident's	d kets aced vide the juired ents.
				representative and first notice bed hold policy will be signed the time of actual transfer, the resident/resident's representa will be notified of bed hold pol again. These forms will be se with the resident on transfer a copy will be made to be kept	. At e ative licy nt and a

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	T OF HEALTH AND HU R MEDICARE & MEDIC					RM APPROVED B NO. 0938-039
STATEME	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 B. WING			(X3) DATE SURVEY COMPLETED 08/04/2022		
	PROVIDER OR SUPPLIE		10466	ADDRESS, CITY, STATE, ZIP COD POLLACK AVE URGH, IN 47630		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
				the resident's medical record.		
				- What measures will be put in place and what systemic char will be made to ensure that the deficient practice does not rec	nges e	
				Nurses have been re-educate the requirements to provide a resident or resident's representative with a bed hold notice when a resident is transferred to a hospital. Pack have been assembled and plat at each nurse's station to provinurses with easier access to the Bed-hold policy and other requipaperwork when discharging/transferring resident At the time of admission, the facility bed hold policy will be verbally explained to resident' representative and first notice bed hold policy will be signed the time of actual transfer, the resident/resident's representative and first notice bed hold policy will be signed the time of actual transfer, the resident/resident's representative and first notice bed hold policy will be made to be kept if the resident's medical record.	d kets aced vide the uired ents.	

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ADON and Medical

Records Coordinator will monitor

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155354	(X2) MULTIPLE CONST A. BUILDING B. WING		instruction 00	(X3) DATE SURVEY COMPLETED 08/04/2022	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
NEWBUF	RGH HEALTH CAR	E			POLLACK AVE JRGH, IN 47630		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
					on a daily basis for 60 (sixty) days. The Medical Records Coordinator will continue to monitor on an ongoing basis.		
					- How the corrective action(s) be monitored to ensure the deficient practice will not recui.e., what quality assurance program will be put into place; and	r,	
					Nurses have been educated or requirements to provide a resion resident's representative wibed hold notice when a reside transferred to a hospital. Pack have been assembled and plate at each nurse's station to provinurses with easier access to the Bed-hold policy and other requipaperwork when discharging/transferring reside. At the time of admission, the facility bed hold policy will be verbally explained to resident's representative and first notice bed hold policy will be signed. The time of actual transfer, the resident/resident's representative will be notified of bed hold policy again. These forms will be ser with the resident on transfer a	dent th a nt is ets iced ride he uired ents. s of At tive icy nt	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155354		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 08/04/2022				ETED	
NAME OF PROVIDER OR SUPPLIER NEWBURGH HEALTH CARE		1	10466 P	ddress, city, state, zip cod POLLACK AVE IRGH, IN 47630			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PR	ID EFIX CAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
					the resident's medical record. The ADON and Medical Records Coordinator will moni on a daily basis for 60 (sixty) of and then weekly for 6 (six) wee Any findings from ADON or Medical Records will be review at the Monthly QAPI meeting.	lays eks.	
					- By what date will the systemichanges for each be	С	
					9/01/2022		

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