STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING 00		COMPLETED		
		155780	B. W	B. WING			05/26/2021	
							_	
NAME OF I	ROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP CODE			
				7465 MADISON AVE				
HOMES	HOMESTEAD HEALTHCARE CENTER			INDIAN	IAPOLIS, IN 46227			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)	16	DATE	
F 0000								
Bldg. 00								
	This visit was for tl	he Investigation of Complaints	F 00	000	Preparation or execution of thi	s		
	IN00353686 and IN	N00353724.			plan of correction does not			
					constitute admission or agreer	ment		
	Complaint IN00353	3686 - Unsubstantiated due to			of provider of the truth of the fa	acts		
	lack of evidence.				alleged or conclusions set fort	h on		
					the State of Deficiencies. The			
	Complaint IN00353	3724 - Substantiated.			Plan of Correction is prepared			
	Federal/State defici	iencies related to the			and executed solely because i	t is		
	allegations are cited	d at F694 and F760.			required by the position of			
					Federal and State Law. The P	lan		
	Survey dates: May	25 and 26, 2021			of Correction is submitted in o	rder		
					to respond to the allegation of			
	Facility number: 01				noncompliance cited during			
	Provider number: 1				annual survey on May 25th-26			
	AIM number: 2009	983560			2021. Please accept this plan	of		
					correction as the provider's			
	Census Bed Type:				credible allegation of complian			
	SNF/NF: 101				The facility would like to reque	st a		
	Total: 101				desk review for this survey.			
	Census Payor Type	<b>::</b>						
	Medicare: 5							
	Medicaid: 85							
	Other: 11							
	Total: 101							
	Thoso deficiencies	noffeet State Findings sited in						
	accordance with 41	reflect State Findings cited in						
	accordance with 41	0 IAC 10.2-3.1.						
	Quality Review con	mpleted on May 28, 2021.						
E 0004	402 25/b\							
F 0694 SS=D	483.25(h) Parenteral/IV Flui	de						
Bldg. 00		=- =						
Diag. 00	§ 483.25(h) Parer	าเerai Fiulds. must be administered						
		ofessional standards of						
	practic <del>e</del> and in ac	cordance with physician						

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

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.

FORM CMS-2567(02-99) Previous Versions Obsolete

TITLE

(X6) DATE

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLI		X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING <u>00</u>			COMPLETED	
		155780	B. WING 05/26/2021					
				STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIEF	₹	7465 MADISON AVE					
HOMESTEAD HEALTHCARE CENTER				INDIAN	IAPOLIS, IN 46227			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			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	ATE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
		ehensive person-centered						
	-	e resident's goals and						
	preferences.						0.6/4.4/2.02.4	
		on, interview, and record	F 0	594	Corrective action for the	_	06/11/2021	
	review, the facility				residents found to have bee	n		
		eripherally Inserted Central as assessed upon admission			affected by the deficient			
		and following intravenous			practice:	v tho		
	_	ration for 1 of 3 residents			Resident B was not harmed by the			
	reviewed for intrav				alleged deficient practice. Resident B has had her IV site			
	Teviewed for intrav	enous therapy.			assessed and appropriate ord			
	Findings include:				are in place for flushing the IV			
	i mamga merade.				site. Resident B's physician h			
	During an interview	v, on 5/25/21 at 3:00 P.M.,		been notified of the alleged		uo		
	_	ed she had been transferred to		deficient practice.				
	the current nursing	home from the facility's			'			
		npany owned by the same			Corrective action taken for			
		d considered a subsidiary of		those residents having the				
		) on 5/10/21. She had been			potential to be affected by th	ne		
	recovering from an	infection following a heart			same deficient practice:			
	valve surgery. Whil	le at the sister facility, she			An audit was conducted by th	е		
	received IV antibio	tics. During the admission			DON/designee on all resident	S		
	process to the curre	ent nursing home, her PICC			that have intravenous orders	to		
	had not been assess	ed. After admission to the			ensure each resident has			
	current nursing hon	ne, for 2 days, her PICC had			appropriate assessment order	rs,		
	not been flushed.				flush orders, and appropriate			
					medication orders. Any reside			
		P.M., the resident was			found out of compliance with			
		PICC in place on the inside of			facility intravenous manageme			
	her upper right arm				policy has been corrected and	d		
	Dania ' '				their plan of care has been			
	_	v, on 5/26/21 at 3:20 P.M., the			updated to reflect accuracy.			
		he had not had any antibiotic			Facility audit completed to engall intravenous lines have order			
	been flushed.	and the PICC line had not			for flushes before and after	<del>2</del> 18		
	occii nusnea.				intravenous medication			
	On 5/26/21 of 2:25	P.M., Resident B's clinical			administration, medications			
		d. Diagnoses included, but			correct and followed per			
		endocarditis (inflammation			physician's orders, and site is			
		of the heart, usually caused by			observed per protocol.			
	l or the nimer mining t	or are mean, assuming eaused by	- 1		assorted per protocol.			

STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETED	
15		155780	B. W	ING		05/26/2021	
		<u> </u>		CTDEET	ADDRESS CITY STATE ZID CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
	TEAD HEALTHOAD	DE CENTED			ADISON AVE		
HOWES I	FEAD HEALTHCAR	CENTER		INDIAN	IAPOLIS, IN 46227		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		s (a condition that occurs					
	1	sponse to an infection			Measures/systemic changes	6	
	_	ssues). The 5 day Minimum			put into place to ensure the		
		nt, dated 5/17/21, indicated			deficient practice does not		
	the resident had no	cognitive impairment.			recur:		
					DON/designee has inserviced	all	
		ssion Evaluation, dated			licensed nursing staff on the		
	•	9 P.M.), indicated no PICC			facilities policy identified as,	:_	
	· ·	the resident was not receiving			"Physician Orders" with emph	iasis	
	antibiotics.				on intravenous orders.	۱ ما۱	
	The Name of Chille	d Evaluation dated 5/14/21			DON/designee has inserviced	ı alı	
	The Nursing Skilled Evaluation, dated 5/14/21, 19:16 (7:16 P.M.), indicated no PICC was				licensed nursing staff on the facilities new admission		
	observed.	illidicated no FICC was			assessment expectations with	,	
	ooserved.				emphasis on assessing for	Į.	
	Δ physician order f	from the facility's sister			intravenous lines.		
		1/20/21 and end date 5/26/21,			maavonous mios.		
		olin Sodium-Dextrose			Corrective actions to be		
	· ·	uted 2-3GM [gram]-%			monitored to ensure the		
		[an antibiotic used to treat			deficient practice will not re	cur:	
		aused by bacteria] Use 2 gram			Director of nursing or designe		
		y 8 hours for endocarditis until			will audit all residents upon		
	5/26/21 23:59 [11:5	59 P.M.]."			admission 5 times per week t	0	
	_				ensure medication orders are		
	A physician order f	from the current facility,			implemented per physician or	ders	
	revision date 5/17/2	21, indicated, "ceFAXolin			and the appropriate assessm	ents	
		Solution Reconstituted			have been completed includir	ng	
	2-3GM-%(50ML)	Use 2 gram intravenously			assessment for intravenous li		
	1	ndocarditis until 5/26/21			Director of nursing or designe		
	23:59 [11:59 P.M.]	".			will audit 5 residents every we	eek	
					for 4 weeks, then 5 residents		
	1 -	from the current facility,			monthly for no less than 3 mo	onths	
	revision date 5/19/21, indicated, "PICC-flush				or until compliance is met.		
	_	ow channel through which					
	· ·	administered] not in use with			The Director of Nursing will		
	_	eter] of saline every 8 hours			present the results of these a		
		]PICC-flush with 10cc of			monthly to the QAPI committee	ee for	
	_	PICC-flush with 10cc of			no less than 3 months. Any		
	saline prior to infus	sion."			patterns that are identified wil		
		1		have an Action Plan initiated.	The	ĺ	

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

PRINTED: 06/08/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155780		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 05/26/2021					
	NAME OF PROVIDER OR SUPPLIER HOMESTEAD HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7465 MADISON AVE INDIANAPOLIS, IN 46227					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE				
	the resident had not	ministration Record indicated received IV antibiotic te following scheduled dates		QAPI committee will determin when 100% compliance is achieved or if ongoing monito is required.					
	5/11/21 0600 P.M.), 2200 (10:00 5/12/21 0600, 5/13/21 0600, 5/26/21 0600,	1400, 2200							
	5/1/21 through 5/31 the resident's PICC	ministration Record, dated /21, lacked documentation had been flushed every 8 ion, and post infusion while							
	Director of Nursing lacked documentation IV antibiotics on 5/6:00 A.M., and there indicate the resident every 8 hours, prior infusion. The 5/10/2 indicated no PICC vereceived no antibiot Skilled Evaluation in observed. The conti	r, on 5/26/21 at 2:00 P.M., the indicated the clinical record on the resident had received 11/21, 5/12/21, and 5/13/21 e was no documentation to the PICC had been flushed to infusion, and post 21 Admission Evaluation was observed, and the resident ics. The 5/14/21 Nursing indicated no PICC was muity of care relative to the otic treatment was not							
	Licensed Practical I uncertain if the residual scheduled morning to the clinical record had not received he it appeared to her the	mission.  7, on 5/26/21 at 3:30 P.M., Nurse 1 indicated she was dent had received her IV antibiotics, and according d, she had not. The resident r 2:30 P.M. IV antibiotics, as e IV antibiotic order had moved from the order list.							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VE3Q11

Facility ID: 012225

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S		SURVEY					
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BU	A. BUILDING 00 COMP			ETED			
155780			B. WING 05/26/2021				2021		
NAME OF D				STREET A	ADDRESS, CITY, STATE, ZIP CODE				
NAME OF P	ROVIDER OR SUPPLIER	s		7465 M	IADISON AVE				
HOMEST	EAD HEALTHCAR	E CENTER		INDIAN	IAPOLIS, IN 46227				
(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' DEFICIENCY)	ΓE	COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE		
		e flushed prior to and							
	following IV antibio	otic administrations.							
	This Federal tag relations IN00353724.	ates to Complaint							
	3.1-47(a)(2)								
F 0760	483.45(f)(2)								
SS=D	Residents are Fre	e of Significant Med Errors							
Bldg. 00	The facility must e	nsure that its-							
	§483.45(f)(2) Residents are free of any								
	significant medication errors.  Based on observation, interview, and record								
			F 0760		observation, interview, and record F 0760 Correcti		Corrective action for the		06/11/2021
	review, the facility	eview, the facility failed to ensure intravenous					residents found to have beer	1	
	antibiotics were adn	ninistered as ordered for 1 of			affected by the deficient				
	3 residents reviewed	d for intravenous medication			practice:				
	therapy.				Resident B was not harmed by	/ the			
					alleged deficient practice.				
	Findings include:				Resident B's medications have	<b>)</b>			
					been reconciled to reflect the				
	_	y, on 5/25/21 at 3:00 P.M.,			physician's orders and are bei	ng			
		d she had been transferred to			administered appropriately.				
	_	home from the facility's			Resident B's physician was				
		npany owned by the same			notified of the missed doses at				
		l considered a subsidiary of			orders were obtained to extend	ו			
		on 5/10/21. She had been			the antibiotic dose until the				
	_	infection following a heart			therapy was complete.				
		e at the sister facility, she			Corrective action taken for				
		tics. During the admission							
	-	nt nursing home, her PICC ed. After admission to the			those residents having the potential to be affected by the	•			
		ne she had not received IV			same deficient practice:	<del>-</del>			
	antibiotics for 2 day				The DON/designee has compl	eted			
	antibiotics for 2 day	s.			an audit on all residents in the				
	On 5/25/21 at 3:00 l	P.M., the resident was			facility. Any resident identified				
		PICC in place on the inside of			having IV antibiotics has been				
	her upper right arm.	-			reviewed to validate that the				
	apper right drift.				medication has been given pe	r the			
	During an interview	y, on 5/26/21 at 3:20 P.M., the			physician order. Any resident				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VE3Q11

Facility ID: 012225

If continuation sheet

Page 5 of 8

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CI		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING <u>00</u>		COMPL	ETED
		155780	B. WING 05/26/20			2021	
				CTREET	ADDRESS SITY STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER	t		1	ADDRESS, CITY, STATE, ZIP CODE		
					ADISON AVE		
HOMESTEAD HEALTHCARE CENTER				INDIAN	APOLIS, IN 46227		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	DROVIDER'S DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	1.2	DATE
	resident indicated s	he had not had any antibiotic			found to have missed doses h	as	
	treatment that day,	and the PICC line had not			had their physician and family		
	been flushed.				notified and new orders obtain	ied	
					to extend the dose of the antib	oiotic	
	On 5/26/21 at 3:25	P.M., Resident B's clinical			to ensure the antibiotic therap	y is	
	record was reviewe	d. Diagnoses included, but			complete.		
	were not limited to,	endocarditis (inflammation			Measures/systemic changes		
		of the heart, usually caused by			put into place to ensure the		
	· ·	(a condition that occurs			deficient practice does not		
	-	ponse to an infection			recur:		
	-	sues). The 5 day Minimum			The DON/designee has inserv		
		t, dated 5/17/21, indicated			all licensed nursing staff on the	е	
	the resident had no	cognitive impairment.			facilities policy identified as,		
					"Physician Orders" and		
		sion Evaluation, dated			"Medication Administration" wi	th	
	· ·	9 P.M.), indicated no PICC			emphasis on IV antibiotic		
		the resident was not receiving			administration.		
	antibiotics.						
	TEL NI ' CI'II	1.E. 1 1. 1.5/1.4/01			0		
		d Evaluation, dated 5/14/21,			Corrective actions to be		
	19:16 (7:16 P.M.), 1 observed.	indicated no PICC was			monitored to ensure the		
	observed.				deficient practice will not rec Director of nursing or designed		
	A mbryainian andan f	ham the facility's sistem			will audit all residents on IV	=	
		from the facility's sister /20/21 and end date 5/26/21,			antibiotic therapy 5 times per		
	•	olin Sodium-Dextrose			week to ensure medication ord	dore	
	· ·	ited 2-3GM [gram]-%			are implemented per physiciar		
		an antibiotic used to treat			orders.	'	
		aused by bacteria] Use 2 gram			Director of nursing or designed	_	
		8 hours for endocarditis until			will audit 5 residents every we		
					for 4 weeks, then 5 residents		
	5/26/21 23:59 [11:59 P.M.]".				monthly for no less than 3 moi	<sub>nths</sub>	
	A physician order f	rom the current facility,			or until compliance is met.		
		1, indicated, "ceFAXolin					
		olution Reconstituted			The Director of Nursing will		
		Jse 2 gram intravenously			present the results of these au	ıdits	
		ndocarditis until 5/26/21			monthly to the QAPI committe		
	23:59 [11:59 P.M.]				no less than 3 months. Any		
	, , , , , , , , , , , , , , , , , , ,				patterns that are identified will		
	Physician's orders f	rom the current facility,			have an Action Plan initiated.		
1	1 -	• /	1		I		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VE3Q11 Facility ID: 012225

If continuation sheet Page 6 of 8

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

PRINTED: 06/08/2021 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155780	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 05/26/2021
	PROVIDER OR SUPPLIER TEAD HEALTHCARE CENTER	STREET. 7465 M INDIAN		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	revision date 5/19/21, indicated, "PICC-flush each lumen [a hollow channel through which medication may be administered] not in use with 10cc [cubic centimeter] of saline every 8 hours and prn [as needed]PICC-flush with 10cc of saline post infusionPICC-flush with 10cc of saline prior to infusion".		QAPI committee will determine when 100% compliance is achieved or if ongoing monitor is required.	
	The Medication Administration Record indicated the resident had not received IV antibiotic administration on the following scheduled dates and times:			
	5/11/21 0600 (6:00 A.M.), 1400 (2:00 P.M.), 2200 (10:00 P.M.) 5/12/21 0600, 1400, 2200 5/13/21 0600 5/26/21 0600, 1400			
	During an interview, on 5/26/21 at 2:00 P.M., the Director of Nursing indicated the clinical record lacked documentation the resident had received IV antibiotics on 5/11/21, 5/12/21, and 5/13/21 6:00 A.M. The 5/10/21 Admission Evaluation indicated no PICC was observed and the resident received no antibiotics. The 5/14/21 Nursing Skilled Evaluation indicated no PICC was observed. The continuity of care relative to the resident's IV antibiotic treatment was not maintained upon admission.			
	During an interview, on 5/26/21 at 3:30 P.M., Licensed Practical Nurse 1 indicated she was uncertain if the resident had received her scheduled morning IV antibiotics, and according to the clinical record, she had not. The resident had not received her 2:30 P.M. IV antibiotics, as it appeared to her the IV antibiotic order had been accidentally removed from the order list.			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VE3Q11

Facility ID: 012225

If continuation sheet

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

PRINTED: 06/08/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
155780		B. WI	NG		05/26	/2021	
NAME OF PROVIDER OR SUPPLIER HOMESTEAD HEALTHCARE CENTER				7465 N	ADDRESS, CITY, STATE, ZIP CODE MADISON AVE NAPOLIS, IN 46227		
(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	TE	COMPLETION
TAG	REGULATORY OR	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	The PICC was to be	e flushed prior to and					
	following IV antibion	otic administrations.					
	This Federal tag rel IN00353724.	ates to Complaint					
3.1-48(c)(2)							
l	l		I		I		l

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: VE3Q11 Facility ID: 012225 If continuation sheet Page 8 of 8