PRINTED: 05/30/2024

	T OF HEALTH AND HU R MEDICARE & MEDIC						IB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155637			A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 05/09/2024	
NAME OF PROVIDER OR SUPPLIER			STREET 6685 E					
CROWN POINT CHRISTIAN VILLAGE				CROW	/N POINT, IN 46307			
(X4) ID		STATEMENT OF DEFICIENCIE		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 DEFICIENCY)	IATE	COMPLETION	
TAG F 0000	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG			DATE	
Bldg. 00	IN00432891, IN00	he Investigation of Complaints 433279, and IN00433545. 2891 - Federal/state deficiencies	F 00	000	The facility kindly requests a review	desk		
	related to the allegated F692.  Complaint IN0043.	ations are cited at F677 and 3279 - Federal/state deficiencies ations are cited at F692.						
	related to the allega	3545 - Federal/state deficiencies ations are cited at F677.						
	Survey dates: May Facility number: 00 Provider number: 1 AIM number: 1004	01198 55637						
	Census Bed Type: SNF/NF: 81 SNF: 22 Residential: 49 Total: 152							
	Census Payor Type Medicare: 16 Medicaid: 56 Other: 31 Total: 103							
	accordance with 41	reflect State Findings cited in 0 IAC 16.2-3.1.						

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

Quality review completed on 5/14/24.

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 X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	A. BUILDING <u>00</u>			COMPLETED	
155637		B. W	B. WING 05/09/2024			/2024	
NAME OF B	ADOLUDED OD GUDDI IED			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	C		6685 E	AST 117TH AVENUE		
CROWN	POINT CHRISTIAN	N VILLAGE		CROW	N POINT, IN 46307		_
(X4) ID	SUMMARY	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		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0677	483.24(a)(2)						
SS=D		ed for Dependent Residents					
Bldg. 00		esident who is unable to					
		of daily living receives the					
	-	es to maintain good					
		g, and personal and oral					
	hygiene;	view and interview, the facility	EA	677	Crown Boint Christian Village	•	05/24/2024
		endent residents received the	F 00	3//	Crown Point Christian Villag	U	05/24/2024
	_	tivities of daily living) care,			Complaint Survey 5.9.24		
		ocumentation of incontinence			Please accept the following as	s the	
		ents reviewed for ADL care.			facility's credible allegation of	o ti iC	
	(Residents F, G, and				compliance. This plan of		
	(1100100111011, 0, 0111						
	Findings include:				admission of guilt or liability by the		
	S				facility and is submitted only in		
	1. Resident F's reco	ard was reviewed on 5/8/24 at			response to the regulatory		
	9:00 a.m. Diagnose	s included, but were not limited			requirement.		
	to Alzheimer's disea	ase, gastrostomy and			F677 ADL Care Provided for		
	colostomy status, ar	nd traumatic brain injury.			Dependent Residents		
					What corrective action(s) wil	I	
		mum Data Set (MDS)			be accomplished for those		
		/9/24, indicated the resident			residents found to have been	n	
		tively impaired for daily			affected by the deficient		
	_	e was dependent on staff for			practice;		
	_	g, but not limited to, oral			Resident F now has		
	hygiene, toileting h	ygiene, and personal hygiene.			documentation of incontinence	Э	
					care every shift.		
	· ·	5/10/23, indicated the resident			Resident G now has		
		re performance deficit.			documentation of incontinence	Э	
		led, but were not limited to,			care every shift.		
	•	d total assistance for toileting			Resident H now has	_	
	and colostomy care	•			documentation of incontinence	<del>5</del>	
	A Care Plan dated	5/18/23, indicated the resident			care every shift.		
		bladder. Interventions			How the facility will identify other residents having the		
		not limited to, check and				10	
	change.	not inflict to, effect and			potential to be affected by the same deficient practice and		
	change.				what corrective action will be	۵	
	The CNA Task - Bi	ladder Continence was			taken;	•	
	LALE CLILL LUON DI						•

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
					COMPL	ETED	
155637		B. W	ING		05/09/	/2024	
			<u>.                                    </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	3			AST 117TH AVENUE		
CROWN	POINT CHRISTIAN	N VILLAGE			N POINT, IN 46307		
(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
	reviewed for the las	st 21 days. The frequency was			All dependent residents have	the	
	every shift. Incont	tinence care was documented			potential to be affected by the		
	once daily on 4/20/2	24, 4/24/24, 5/2/24, 5/5/24, and			same alleged deficient practic	e.	
	5/7/24. Incontinenc	e care was documented twice			What measures will be put in	ito	
	1	/25/24, 4/27/24, 4/28/24, 4/29/24,			place or what systemic		
	and 5/3/24.		1		changes will be made to		
					ensure that the deficient		
	_	v on 5/9/24 at 11:23 a.m., the			practice does not recur;		
	Director of Nursing	g indicated staff should have			Staff were re-educated on		
	documentation of in	ncontinence care at least every			providing residents with		
	shift.				assistance with ADLs per		
	2. Resident G's record was reviewed on 5/8/24 at				resident's plan of care includir	ng	
					documenting at least once per	r	
	1:08 p.m. Diagnosis	s included, but were not limited			shift that incontinence care ha	s	
	to, Alzheimer's dise	ease and dementia.			been provided.		
					How the corrective action(s)		
	The Quarterly Mini	imum Data Set (MDS)			will be monitored to ensure t	:he	
	assessment, dated 3	3/7/24, indicated the resident			deficient practice will not		
	was severely cognit	tively impaired. He was			recur, i.e., what quality		
	dependent on staff	for activities of daily living			assurance programs will be	put	
	(ADLs) including,	but not limited to, oral hygiene,			into place;		
	toileting hygiene, a	nd personal hygiene.			DON/Designee will audit 10		
					dependent residents 2xs/week	< for	
		9/11/20, indicated the resident			6 months to ensure they have		
		nence. Interventions included,			documentation of incontinence	9	
	but were not limited	d to, check and change.			care at least every shift.		
					Director of Nursing/designee v	vill	
	A Care Plan, dated	10/26/21, indicated the resident			present a summary of the aud	its	
	had an ADL self-ca	are performance deficit.			to the Quality Assurance		
		ded, but were not limited to,			committee monthly for 6 mont	hs.	
	the resident require	d extensive assistance for			Thereafter, if determined by th	ne	
	toileting.		1		Quality Assurance committee,		
			1		auditing and monitoring will be	)	
		ladder Continence was			done quarterly and present		
		st 21 days. The frequency was			quarterly at the QA meeting.		
	every shift. Incont	tinence care was documented			Monitoring will be on going.		
	once daily on 4/24/2	24 and 5/5/24. Incontinence					
	care was document	ed twice daily on 4/17/24,			Date of completion: 5.24.24		
	4/20/24, 4/22/24, 4/	/25/24, 4/27/24, 4/30/24, 5/1/24,	1				
	5/3/24 and 5/7/24						

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			0	MB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DAT	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING	00	COM	COMPLETED		
155637			B. WING		05/0	9/2024	
NAME OF PROVIDER OR SUPPLIER  CROWN POINT CHRISTIAN VILLAGE			6685 E	ADDRESS, CITY, STATE, ZIP COD AST 117TH AVENUE N POINT, IN 46307	<u> </u>		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	1		(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL	D BE	COMPLETION	
	·			CROSS-REFERENCED TO THE APPRODEFICIENCY)	OPRIATE		
TAG	During an interview Director of Nursing documentation of ir shift.  3. Resident H's reco 2:52 p.m. Diagnose to, dementia, anxiet communication defit The Quarterly Mini assessment, dated 3 was cognitively into She was dependent  A Care Plan, dated needed assistance wincluded, but were required extensive at A Care Plan, dated had incontinence an complications. Internot limited to, inconincontinence episod The CNA Task - Bl reviewed for the las every shift. There we documented on 4/25/24, 4/27/24, 5/care was documented 4/28/24, 4/29/24, 5/care was documented 4/28	mum Data Set (MDS) /28/24, indicated the resident act for daily decision making. on staff for toilet hygiene.  10/5/23, indicated the resident with ADLs. Interventions not limited to, the resident assistance for toileting.  4/1/24, indicated the resident d was at risk for eventions included, but were ntinence care with each	TAG	DEFICIENCY)	J. NATE	DATE	
	documentation of in	continence care at least every	1				

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shift.

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	T OF HEALTH AND HU R MEDICARE & MEDIC						B NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155637	A. BUI	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 05/09/2024	
NAME OF PROVIDER OR SUPPLIER CROWN POINT CHRISTIAN VILLAGE				6685 E	ADDRESS, CITY, STATE, ZIP COD AST 117TH AVENUE N POINT, IN 46307			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
	This citation relates IN00433545. 3.1-38(2)(C)	to Complaint IN00432891 and						
F 0692 SS=D Bldg. 00	§483.25(g) Assist (Includes naso-ga tubes, both percu gastrostomy and jejunostomy, and	n Status Maintenance ed nutrition and hydration. estric and gastrostomy taneous endoscopic percutaneous endoscopic enteral fluids). Based on a hensive assessment, the re that a resident-						
	parameters of nut usual body weigh range and electro							
	to maintain prope §483.25(g)(3) Is of when there is a new	ffered sufficient fluid intake r hydration and health;  ffered a therapeutic diet utritional problem and the						
	Based on record re- failed to ensure phy related to an incorr documented and in- logs for residents w	der orders a therapeutic diet. View, and interview, the facility visician's orders were followed eet amount of enteral feeding complete meal consumption with a history of weight loss for diewed for nutrition. (Residents	F 069	92	Crown Point Christian Village Complaint Survey 5.9.24 Please accept the following as facility's credible allegation of compliance. This plan of correction does not constitute	the	05/24/2024	

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Findings include:

Event ID:

XW9J11

Facility ID: 001198

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admission of guilt or liability by the

facility and is submitted only in response to the regulatory

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155637		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY  COMPLETED  05/09/2024	
NAME OF PROVIDER OR SUPPLIER  CROWN POINT CHRISTIAN VILLAGE		6685 E	ADDRESS, CITY, STATE, ZIP COD EAST 117TH AVENUE VN POINT, IN 46307		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	(X5) COMPLETION
TAG		rd was reviewed on 5/8/24 at	TAG	DEFICIENCY)	DATE
		rd was reviewed on 5/8/24 at s included, but were not limited		requirement. F692 Nutrition/Hydration Sta	atue
	•	ase, gastrostomy and		Maintenance	atus
		nd traumatic brain injury.		What corrective action(s) wi	ill
				be accomplished for those	
		mum Data Set (MDS)		residents found to have bee	n
	· · · · · · · · · · · · · · · · · · ·	/9/24, indicated the resident		affected by the deficient	
		ively impaired for daily		practice;	
	_	e had a feeding tube. He		Resident F had an incorrect	
		ore of his total calories and 501		documented amount of enter	aı
	cc per day or more fluids through the feeding tube.			feeding documented and incomplete meal consumption	
	A Care Plan, dated 6/7/23, indicated the resident			logs. Resident F's documenta	
				for enteral feeding and meal	ation
		ling. Interventions included,		consumption is now updated	and
	_	I to, feed via tube feed pump		accurate, RD continues to fol	
	per Physician's orde			for Nutrition at Risk.	
	1 2			Resident G had incomplete m	neal
	A Physician's Order	r, dated 8/9/23, indicated		consumption logs. Resident (	
	Osmolite 1.5 at 72 i	milliliter per hour for 20 hours,		documentation for meal	
	on at 1:00 p.m. and	off at 9:00 a.m.		consumption is now updated	and
				complete, RD continues to fo	llow
	•	r, dated 6/13/23, indicated		for Nutrition at Risk.	
		ding intake every shift and		Resident H had incomplete m	
	document amount a	dministered.		consumption logs. Resident I	d's
	The Amil 202434	diagtion Administration Decree		documentation for meal	
	-	dication Administration Record		consumption is now updated	
		e resident received the ral feeding amounts per day:		complete, RD continues to fo	llow
	- 4/17/24: 1,590 mil			for Nutrition at Risk.  How the facility will identify	
	- 4/18/24: 1,441 ml	* *		other residents having the	
	- 4/19/24: 1,185 ml			potential to be affected by the	he
	- 4/20/24: 1,543 ml			same deficient practice and	
	- 4/21/24: 1,953 ml			what corrective action will be	
	- 4/22/24: 1,396 ml			taken;	
	- 4/23/24: 976 ml			All residents with a history of	
	- 4/24/24: 882 ml			weight loss have the potentia	l to
	- 4/25/24: 976 ml			be affected by the same alleg	
	- 4/26/24: 2,456 ml			deficient practice.	
	- 4/27/24: 1,586 ml			What measures will be put i	nto

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	A. BUILDING <u>00</u>		COMPLETED		
155637		B. WING 05/09/2024			/2024		
		<u> </u>	1	CTDEET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	₹					
CDOMA	DOINT CUDISTIAN	AVILLAGE			AST 117TH AVENUE		
CROWN	POINT CHRISTIAN	N VILLAGE		CROW	N POINT, IN 46307		
(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
	- 4/28/24: 1,303.5 r	nl			place or what systemic		
	- 4/29/24: 1,446 ml				changes will be made to		
	- 4/30/24: 975 ml				ensure that the deficient		
					practice does not recur;		
	_	v on 5/9/24 at 12:35 p.m., the			Nurses, QMA's and CNAs we	re	
	_	g indicated the staff had			in-serviced to ensure that all		
		he feeding pump which led to			accurate documentation of me	eal	
	inaccurate documer	ntation of the enteral feeding.			consumptions and enteral		
					feedings are completed daily.		
		ord was reviewed on 5/8/24 at			How the corrective action(s)		
		s included, but were not limited			will be monitored to ensure	the	
	to, Alzheimer's dise				deficient practice will not		
	gastrostomy status.				recur, i.e., what quality		
		D			assurance programs will be	put	
		mum Data Set (MDS)			into place;		
		3/7/24, indicated the resident			DON/Designee will review 10		
		tively impaired. He received			residents' meal consumption		
		feeding tube and also had a			documentation and all tube fe	•	
	mechanically altere	d and therapeutic diet.			documentation on MAR 5x/we	eek	
	TI M 2024 DI	0.1.6			for 6 months.		
		sician Order Summary indicated			The Director of Nursing/design	nee	
		a mechanical soft diet with			will present a summary of the	_	
	thin liquids.				audits to the Quality Assurance		
	A Care Dlan datad	4/25/22, indicated the resident			committee monthly for 6 mont		
		ition problem. Interventions			Thereafter, if determined by the Quality Assurance committee.		
	_	not limited to, provide diet per			auditing and monitoring will be		
	order, monitor intal	• • • • •			1	<del>5</del>	
	order, moment intar	te and record.			done quarterly and present quarterly at the QA meeting.		
	The CNA Task - Fa	ating ADL (activity of daily			Monitoring will be on going.		
		ere was no breakfast meal			Date of completion: 5.24.24		
		4/24, 4/26/24, 4/27/24, and			24.0 01 00111pletion: 0.24.24		
		no lunch meal documented on					
		4. There was no dinner meal					
		8/24, 4/20/24, 4/22/24, 4/24/24,					
	4/25/24, 4/30/24, 5/						
	,	,					
	During an interview	v on 5/9/24 at 11:23 a.m., the					
	_	g indicated she was unable to					
	provide any further						

l í		r í	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
		A. BUILDING 00 COMPLETED  B. WING 05/09/2024					
155637			B. W	ING		05/09/	2024
NAME OF PROVIDER OR SUPPLIER  CROWN POINT CHRISTIAN VILLAGE				6685 EA	NDDRESS, CITY, STATE, ZIP COD AST 117TH AVENUE N POINT, IN 46307		
(X4) ID			1	ID			(V5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LISC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
	2:52 p.m. Diagnose to, dementia, anxiet communication defined to the Quarterly Minited assessment, dated 3 was cognitively into the resident's weigh weighed 101.8 pour 96.4 pounds on 5/7/ The May 2024 Physisthe resident receives food with all meals wound that returned the A current Care Plan nutritional problem wound healing. Internot limited to, proving and monitor intake  The CNA Task - Ealiving) indicated the documented on 4/18 4/29/24, and 5/2/24 documented on 4/20 4/29/24, and 5/2/24, and 5/2/24 documented on 4/20 4/28/24, 5/2/24, 5/4  During an interview Director of Nursing information to proving the communication of the proving the province of the provinc	mum Data Set (MDS)  /28/24, indicated the resident act for daily decision making.  ht log indicated the resident ads on 4/7/24. She weighed  /24.  sician Order Summary indicated d a regular diet with fortified due to weight loss and a  ht.  a, indicated the resident had a related to increased needs for erventions included, but were ide and service diet as ordered and record each meal.  atting ADL (activity of daily are was no breakfast meal  //24, 4/22/24, 4/24/24, 4/25/24,  There was no lunch meal  //24, 4/22/24, 4/24/24, 4/25/24,  There was no dinner meal  //24, 4/24/24, 4/25/24, 4/27/24,  //24, 5/5/24, and 5/6/24.  // on 5/9/24 at 11:23 a.m., the indicated she had no further					

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

PRINT FOR

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FORM APPROVED OMB NO. 0938-039

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155637	B. WING			05/09/2024	
NAME OF PROVIDER OR SUPPLIER  CROWN POINT CHRISTIAN VILLAGE			STREET ADDRESS, CITY, STATE, ZIP COD 6685 EAST 117TH AVENUE CROWN POINT, IN 46307				
(X4) ID	SUMMARY S	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	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	3.1-46(a)(1)						

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