

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

PRINTED: 05/06/2014
FORM APPROVED
OMB NO. 0938-0391

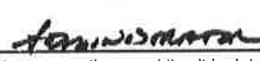
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/25/2014
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTHCARE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 OCEAN VIEW BLVD LEWES, DE 19958	
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced complaint survey was conducted at this facility from April 13, 2014 through April 25, 2014. The deficiencies cited in this report are based on record reviews, staff interviews, observations and review of other facility documentation as indicated. The census the first day of the survey was 167. The sample size included three (3) active records and two (2) closed records.	F 000		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews it	F 280	A. R1 was discharged from the facility. R 3's individualized care plan was reviewed and update by the DON/designee to address preferences/needs for bathing. B. The facility completed a focus review of all residents currently in house to verify that those identified with poor intake and weight loss were being monitored as indicated. A review was also completed of resident's bathing schedules and associated compliance. Identified care plans were updated to ensure that care needs related to nutrition and bathing reflected appropriate interventions.	6/2/14

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

TITLE

(X6) DATE





5/16/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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.

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

PRINTED: 05/06/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/25/2014
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTHCARE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 OCEAN VIEW BLVD LEWES, DE 19958	
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 1 was determined that for two (2) of five (5) residents reviewed (R1 and R3) the facility failed to review and revise the comprehensive care plan in response to identified changes in care needs. R1 had poor meal intake consistently documented along with weight loss without corresponding care plan revision. R1 also had unmet hygiene / bathing needs which were not addressed in his care plan. R3 had a pattern of refusing baths and showers but his care plan was not revised to identify how his bathing needs would be met. Findings include: 1. Cross-refer F325 and F312 example 2. R1 had a care plan addressing his risk for alteration in nutrition. Despite documented poor meal intake and weight loss, this care plan was not reviewed and revised by the facility to ensure that R1's care needs related to nutrition were met. R1 also had a care plan instructing staff to assist with daily hygiene as needed. For uncertain reasons, R1 only received two baths in the 19 days prior to his discharge from the facility. There was no care plan revision to identify an individualized plan for how the facility planned to meet R1's need for bathing. 2. Cross-refer F312, example 1. R3 had a care plan instructing staff to assist with daily hygiene as needed. Despite repeated documentation of refusing showering and bathing, the facility failed to review and revise R3's care plan to ensure that individualized approaches to meet his bathing needs were implemented.	F 280	C. It was determined that the care plans for residents were not being updated to reflect current care and services. On a daily basis, residents identified for refusals of showers/hygiene will be interviewed for preferences of bathing and shower schedules (see attached) with associated plan of care revised accordingly. Policies and procedures were reviewed and no revisions were necessary to achieve regulatory compliance. All licensed staff will be in-serviced on care planning/updating according to policy by DON/designee. D. DON/designee will conduct daily audits until 100% compliance is reached over 3 consecutive evaluations. Then the DON/designee will conduct audits 3 times per week until 100% compliance is achieved over 3 consecutive evaluations. Then the DON/designee will conduct audits once per week until 100% compliance is achieved over 3 consecutive evaluations.	
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS			

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

PRINTED: 05/06/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/25/2014
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTHCARE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 OCEAN VIEW BLVD LEWES, DE 19958		
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 312	<p>Continued From page 2</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, it was determined that for two (2) of five (5) residents reviewed (R3 and R1) the facility failed to ensure that the necessary services to maintain personal hygiene were provided. A pattern of refusing scheduled showers was documented in the clinical record for R3. R1 received only bed baths (no showers) during a two month stay in the facility for undocumented reasons. The facility failed to develop and implement an alternate plan or schedule for bathing / showering to ensure that R3 and R1 maintained their personal hygiene. Findings include:</p> <p>1. R3 was documented in the clinical record as having refused 8 of 14 scheduled showers in March and April of 2014. On three of these 8 occasions (3/3/14, 3/10/14, and 3/17/14) R3 also refused a bed bath. When asked about R3's shower and bathing refusals on 4/14/14 at 11:50 AM, E4 (Licensed Practical Nurse) stated that R3 did not refuse. A few minutes later, E4 stated to the surveyor that she just became aware of R3's shower refusal since they occurred on another shift (3 PM to 11 PM) not the day shift.</p> <p>On 4/22/14 at 5:45 PM, E5 (Registered Nurse/RN, Unit Manager) stated to the surveyor that she was unaware of R3's shower and bathing refusals until the survey but that the staff should</p>		<p>Finally, the DON/designee will conduct an audit one month later. If 100% compliance is achieved, the facility will conclude the deficiency has been corrected, and the audit will be completed randomly every 6 months to assess continued compliance with processes.</p> <p>The results of the audits will be reviewed and reported to the facility QA Committee monthly.</p>		

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

PRINTED: 05/06/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/25/2014
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTHCARE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 OCEAN VIEW BLVD LEWES, DE 19958	
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 3 have made her aware. E5 explained that another nurse co-signed the refusals according to the facility's established practice but forgot to inform her (E5) of the issue. E5 stated that after evaluating the situation, the staff realized that R3 does not refuse bathing on the day shift so they changed his bathing schedule from evening shift to day shift. R3's care plan for self-care deficit developed on 3/13/14 instructed staff to assist with daily hygiene as needed but had failed to include his individual preference on the timing (day or evening) of his bathing. 2. Clinical record documentation for R1 revealed that in the 19 days prior to his discharge from the facility on 4/8/14, R1 had just two (2) bed baths (3/27/14 and 3/31/14) and no showers. On 4/3/14 and 4/7/14 a staff member documented that no shower was given because the schedule was wrong. R1's care plan for self-care deficit developed on 2/27/14 instructed staff to assist with daily hygiene as needed, however, there was no individualized plan developed and bathing became less frequent during R1's stay in the facility. Findings were reviewed with E1 (Administrator), E2 (RN) and E6 (corporate representative) on 4/25/14 at 1:45 PM.	F312	A. R1 was discharged from the facility. R 3's bathing schedule was modified to reflect individual preferences. B. The facility completed focus review of all residents related to individual bathing schedules and associated compliance. Identified issues were immediately addressed and care plans were updated to ensure that care needs and bathing reflected appropriate interventions. C. On a daily basis, residents identified for refusals of showers/hygiene will be interviewed for preferences of bathing and shower schedules (see attached) with associated plan of care revised accordingly. All licensed staff will be in-serviced on system changes for monitoring and individualized plan development for bathing/shower schedules according to policy by DON/designee.	6/2/14
F 325 SS=E	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition			

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

PRINTED: 05/06/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/25/2014
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTHCARE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 OCEAN VIEW BLVD LEWES, DE 19958		
(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 APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 325	<p>Continued From page 4 demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and review of other documentation as indicated, it was determined that for one (1) resident reviewed (R1) the facility failed to ensure that the resident maintained an acceptable parameter of nutrition status (body weight). After weights obtained by facility staff indicated a severe weight loss, the facility failed to re-weigh R1 as required by facility nursing guidelines to determine the validity of the weight loss. In addition, the facility failed to identify that meal intake documentation showed that R1 usually ate 50% or less of his meals. There was no evidence that the low meal intake was evaluated as a possible contributing factor to R1's weight loss. Findings include:</p> <p>R1 had documented weights of 188.2 pounds on 2/25/14 and 165.4 pounds on 3/3/14 indicating a 22.8 pound weight loss or 12% in a week. The facility's nursing guidelines required that a re-weight be obtained as soon as possible (within 24 hours) when a weight loss was identified but this did not occur for R1 until a week later. Re-weights on 3/10/14 were: -173.5 pounds at 9:34 AM (a 7.8% body weight loss in 180 days as documented in the clinical record); and -169.2 pounds at 2:57 PM (a 10% body weight loss in 90 days as documented in the clinical record).</p>		<p>D. DON/designee will conduct daily audits until 100% compliance is reached over 3 consecutive evaluations. Then the DON/designee will conduct audits 3 times per week until 100% compliance is achieved over 3 consecutive evaluations. Then the DON/designee will conduct audits once per week until 100% compliance is achieved over 3 consecutive evaluations. Finally, the DON/designee will conduct an audit one month later. If 100% compliance is achieved, the facility will conclude the deficiency has been corrected. The results of the audits will be reviewed and reported to the facility QA Committee monthly.</p>		

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

PRINTED: 05/06/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 086034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/26/2014
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTHCARE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 OCEAN VIEW BLVD LEWES, DE 19958		
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 325	<p>Continued From page 5</p> <p>This confirms that R1 had lost a severe amount of body weight (although the exact amount was not clear) and that the facility should have evaluated possible reasons and implemented a plan to address them.</p> <p>Clinical record review revealed:</p> <p>-A care plan was developed by the facility on 2/17/14 (near the time of admission) to address R1's risk for alteration in nutrition related to dementia. Instructions included: assist with meals as needed, monitor food intake and weight, weights as required by policy.</p> <p>-Meal intake documentation for R1 indicated that R1 usually ate 50% or less of his meals , however, no changes to the care plan were made. R1's documented meal intake was 50% or less for: ~35 out of 45 meals in February, 2014 (78%); ~58 out of 93 meals in March 2014 (62%); and ~10 out of 23 meals in April, 2014 (43%) prior to R1's discharge on 4/8/14.</p> <p>-Facility staff identified R1 as independent with eating on multiple Minimum Data Set (MDS) assessments (standardized assessment tools used in nursing homes) dated 2/20/14, 2/27/14, April 3, 2014 and April 8, 2014. One MDS assessment dated 3/13/14, however, indicated that R1 required extensive staff assistance with meals (physical help with eating). In addition, a verbal physician's order dated 3/4/14 identified R1 as being dependent on staff assistance for all meals. It was unclear from clinical record review if or how this order was actually implemented.</p>	F 325	<p>A . Resident R1 has been discharged from the facility.</p> <p>B. All residents were reviewed for weight change along with corresponding documentation, interventions and changes to the care plans. Weight changes will be reviewed during the weekly IDC meetings. Unit Managers/Designee will report in AM meeting fluctuations from baseline in meal intake over a 3 day period and assistance requirements with meals will be reviewed. The RD and nursing staff will be inserviced on the weight and reweight policy. The RD was educated on proper input of weights along with timely nutrition documentation, interventions and changes to the care plan. The RD was educated on the policy for "identifying patients at nutrition risk".</p> <p>C . The root cause analysis was completed and system changes identified. Per facility policy, upon admission, weekly weights will be taken x 4 weeks.</p>	6/2/14	

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

PRINTED: 05/06/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/25/2014
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTHCARE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 OCEAN VIEW BLVD LEWES, DE 19958		
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 325	<p>Continued From page 6</p> <p>E3 (Registered Dietitian) evaluated R1 at the time of his admission and documented on 2/17/14 that R1's food intake was slightly below adequate. When interviewed by the surveyor on 4/16/14 at 9:55 AM, E3 acknowledged that she had not re-evaluated E3 after his weight loss. E3 explained that she usually does the re-weights herself but R1's re-weight was erroneously missed. E3 acknowledged that R1's weight loss was not reviewed by the interdisciplinary team. Consequently, the facility failed to identify and implement a plan for staff to follow to address R1's poor meal intake in light of recent weight loss.</p> <p>R1 experienced weight loss in the facility when his meal intake documentation indicated that he was usually eating 50% or less of his meals. The facility failed to evaluate possible reasons for the weight loss, including poor meal intake, and failed to develop a plan to address the weight loss. A physician's order indicated that R1 was dependent on staff assistance for meals, however, facility staff assessed R1 multiple times as independent with eating. The same (unchanged) nutrition risk care plan remained in effect for R1 during his two month stay in the facility despite weight loss and poor meal intake.</p> <p>Findings reviewed with E1 (Administrator), E2 (Registered Nurse) and E6 (corporate representative) on 4/25/14 at 1:45 PM.</p>	F 325	<p>Then, if stable, resident will transition to monthly weights. If a fluctuation in weight is identified, the RD will communicate with the Unit Manager/Designee the need for a reweight. A reweight will be conducted and communicated back to the RD. The RD will then review the residents' plan of care, assess for interventions and implement as required. Residents identified with weight loss will be reviewed with the Medical Director/Interdisciplinary team weekly. The care plan will be evaluated and updated as necessary.</p> <p>D. A weight loss audit (attached) for patients with significant weight changes will be done weekly by the RD x 4 weeks or until 100% compliance for 2 consecutive weeks. The audit will then be done twice a month x 2 months until 100% compliance for 2 consecutive audits. To maintain compliance, a weight loss audit will be done monthly. The results of the audits will be reviewed and reported to the facility QA Committee monthly.</p>		



**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

Page 1 of 2

NAME OF FACILITY: Harbor Health Care

DATE SURVEY COMPLETED: April 25, 2014

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
<p>3201</p> <p>3201.1.0</p> <p>3201.1.2</p>	<p>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</p> <p>An unannounced complaint survey was conducted at this facility from April 13, 2014 through April 25, 2014. The deficiencies cited in this report are based on record reviews, staff interviews, observations and review of other facility documentation as indicated. The census the first day of the survey was 167 . The sample size included three (3) active records and two (2) closed records.</p> <p>Regulations for Skilled and Intermediate Care Facilities</p> <p>Scope</p> <p>Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.</p> <p>This requirement is not met as evidenced by:</p>	<p>3201.1.2</p> <p>Cross refer to the CMS 2567-L survey ending 4/25/14, F280, F312 and F325.</p> <p>Completion Date: 6/2/14</p>

Provider's Signature  Title Administrator Date 5/16/14



**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

Page 2 of 2

NAME OF FACILITY: Harbor Health Care

DATE SURVEY COMPLETED: April 25, 2014

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
---------	--	--

	Cross refer to the CMS 2567-L survey ending 4/25/14, F280, F312, and F 325.	
--	---	--

Provider's Signature _____ Title _____ Date _____