PRINTED: 01/05/2018 FORM APPROVED OMB NO 0938-0391

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIERICLIA IDENTIFICATION NUMBER:		(X2) MUL	(X3) DATE SURVEY	
			A. BOILE	DING ——————	l c
		095039	B. WING		01/03/2018
	PROVIDER OR SUPPLIER MEDICAL NURSING 1	IONE		STREET ADDRESS, CITY, STATE, ZIP CODE 1310 SOUTHERN AVENUE, SE, SUITE 20	
	MEDIONE NONSING P	IOME		WASHINGTON, DC 20032	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 000	INITIALCOMMENT	S	F 00	00	
	was initiated on Oct deficiencies were ba	pation for C-18-008, DC-3461, ober 26, 2017. The following ased on observation, staff and and record review. The residents.		,	
	NP - Nurse Pra BID - Twice-a-d EMS- Emergency HVAC - Heating Ve Neuro - Neurologi B/P - Blood Pre CRF - Commun CNA- Certified Ni DMH - Departme Peg tube - Percutane Gastrostomy NP - Nurse Pra L- Liter DI - Deciliter CMS - Centers fo Services Lbs- Pounds (u MAR- Medication MD- Medical Do MDS- Minimum I Mg- Milligrams	omy tube dectrocardiogram detitioner day Medical Services (911) entilation/Air conditioning cal ssure dity Residential Facility urse Aide ent of Mental Health dous Endoscopic ectitioner or Medicare and Medicaid entit of mass) endoscopic data Set (metric system unit of mass) metric system measure of er Deciliter	(*)		
F	POCT - Point of Co				
BORATORY	DIRECTOR'S OR PROVIDER	VSUPPLIER REPRESENTATIVE'S SIGNA	TURE	TITLE	(X6) DATE

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.

		A MEDICAID SERVICES			OMB N	0 0938-039
AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDERISUPPLIERICLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ULDING	(X3) D	ATE SURVEY DMPLETED
		095039	B. WING		0	C 1/03/2018
NAME OF	PROVIDER OR SUPPLIER	***************************************		STREET ADDRESS, CITY, STATE, ZIP CODE		1/05/2010
UNITED	MEDICAL NURSING H	IOME		1310 SOUTHERN AVENUE, SE, SUITE 20 WASHINGTON, DC 20032		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	TION	
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	PREFIX TAG		ULD BE	(X5) COMPLETIC DATE
F 000	Continued From pa	ge 1	, F00	00		
F 456 SS=D	Prn- As needed Pt- Patient TAR- Treatment PASRR - Preadmiss Review ARD - Assessment IDT- Intellectual ID- In	t Administration Record sion Screen and Resident ant Reference Date inary Team al Disability dicator Survey Columbia The Party PO-MENT, SAFE OPERATING The Columbia and the co	F 45		rred to ere he ound to uis nedical with a orders for have	8/25/17
1	2.1, last reviewed Ju	ne 28, 2017, the following 3 of 15: "Quality Control		calibrated, serviced and stocked		1///18

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES		PP	RINTED: 01/05/201 FORM APPROVE
STATEMENT	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDERISUPPLIER/CLIA IDENTIFICATION NUMBER:	1		MB NO 0938-039 (X3) DATE SURVEY COMPLETED
MANAE OE	220,1122, 22, 21, 22, 152	095039	B. WING		C 01/03/2018
NAME OF 1	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
UNITED	MEDICAL NURSING H			1310 SOUTHERN AVENUE, SE, SUITE 200 WASHINGTON, DC 20032	
(X4) ID PREFIX TAG	(EACH DEFICIENCY I	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	SE (XS) ATE DATE
	(QC) Testing: The foreach new day of test procedure performant specimen. a. The assigned nor solutions will be tested. The control solution their pre-established	pollowing will be performed on sting to confirm the test unce before testing any patient rmal and abnormal control ed. Tons results must fall within tranges before any patient	F 450	6 3. To prevent future occurrences an ensure availability for emergency u one Glucose Meter has been identif (labeled), on each unit and will be recalibrated at 1:00am daily. All licensed nursing staff will be recalibrated at 1:00 and staff will be recalled to the first staff of the staff	ise, fied
	testing can be performed. The QC reagents we be recorded on the GLog that is stored in the Notebook"	rmed. with other information must Glucose Meter Multi-Task QC the department POCT QC		educated on the "Accu-Chek Inform Glucose Meter Test Procedure", to include the Quality (QC) Testing calibration, to ensure compliance.	n II Ongoing
; ; ;	Resident #2 requeste Employee #4 to "char #1)." Facility staff atte required incontinent of subsequently slid off required four (4) staff	inge his roommate (Resident tended to Resident #1, who care. Resident #1 the bed onto the floor and f members to place him/her	Te .	The night shift nursing supervisor was the responsible for ensuring nightly calibration of glucometers on each under the same of the same	unit. Ongoing
t t	unresponsive. Facility and Employee #4 tool was initiated and the I	me, Resident #1 became y staff assessed the resident ok his/her blood sugar. CPR resident was transferred to , where he was pronounced		Manager/designee daily and added a nursing quality indicator to ensure compliance until three consecutive months of greater than or equal to 95 compliance is achieved. Results of the compliance of the compliance is achieved.	5%
ro s	"At about 4:42AM on a room 7048 came to th stated that "my roomn I was the only one visi	ee #4's written statement, 8/25/17, the resident in he nursing station and mate needs to be changed." ible at the nursing station at other two charge nurses	ě	audits will be provided to the DON will present at the quarterly Quality Assurance committee meeting. The QAC will ensure oversight and correction of any identified deficience.	who

and the CNAs were at the back nursing station. I called the charge nurse who had that assignment

Employee #5 and told him/her that his/her resident in room 7048 need to be changed. He/she now called the CNA and they both went to the resident. At no point did the charge nurse or

5. Corrective action completion date: 1/16/18

		WINEDIONID OF LANCES			NMR NO	0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIERICLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095039	B. WING			C /03/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
UNITED	MEDICAL NURSING H	IOME		1310 SOUTHERN AVENUE, SE, SUITE 200 WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(XS) COMPLETION DATE
	the CNA who went to resident was in distranceded to be chang for injuries, no apparany acute distress, yourses back to his/hothey need to get his/get the glucometer to resident. I tried three was not able to use a have not been calibrate one of the meters be sugar. The charge in the resident at the timand the resident was A telephone interview 27, 2017 at 9:40AM the use of the glucometers are usually callimorning blood sugar each of the glucometer calibrated by the nighthe meters so I could blood sugar. He/she to three minutes, may not broken. They wer Facility staff failed to three (3) glucometers available for emergent Employee #6 acknow telphone interview contents.	o the resident say that the ess other than resident edResident was assessed rent injuries noted, was not in vas lifted off the floor by four er bed. I told the nurse that ther vital signs while I went to be do finger stick on the different glucometers but anyone of them because they ated. I ended up calibrating afore I could check his/her urse and the CNAwas with me providing care to him/her onto in any acute distress" It was conducted on October with Employee #4 regarding meters on August 25, 2017 at ted, "The glucometers have midnight every night. They is the built into the machine. It is built into the machine. It is built into the machine. It is a diabetic. It took me two ybe less. The meters were e just not calibrated." maintain at least one (1) of it to be immediately not use. Indicated on November 13, indicated on November 13,	F 456			
	2017 The record was	reviewed October 24	- 1			

CENTERS FOR MEDICARE & MEDICAID SERVICES						FOR	D: 01/05/2018 M APPROVED	
STATEMENT OF DEFICIENCIES (X1) PROVIDERISUPPLIER/CLIA				LTIPI	LE CONSTRUCTION	OMS NO 0938-0391 (X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				ILDING	CC	MPLETED		
		095039	B WING		•	1	c	
NAME OF	PROVIDER OR SUPPLIER	033039	B WING		STREET ADDRESS, CITY, STATE, ZIP CODE	0:	1/03/2018	
LIMITED	MEDICAL NURSING H	IOME.			1310 SOUTHERN AVENUE, SE, SUITE 200			
ONTE	WEDICAL NUASING F	OME			WASHINGTON, DC 20032			
(X4) ID PREFIX TAG	I (EACH DEFICIENCY)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ζ	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 456	Continued From page	ge 4	F	156				
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PRINTED: 01/05/2018 FORM APPROVED OMB NO 0938-0391

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIERICLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING — — — — — — —			(X3) DATE SURVEY COMPLETED	
		A. BUILD	NG	С			
		095039	B. WING			03/2018	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
UNITED	MEDICAL NURSING I	HOME		1310 SOUTHERN AVENUE, SE, SUITE 200			
				WASHINGTON, DC 20032			
(X4) ID PREFIX		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
TAG	REGULATORY OR L	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETION	
		•	77.0	DEFICIENCY)	INIC		
F000	INITIALCOMMENT	S	F00	0			
				1			
	A complaint investig	gation for C-18-008, DC-3461,		1			
	was initiated on Oct	ober 26, 2017. The following					
	deficiencies were b	ased on observation, staff and		1			
1		and record review. The		1	1		
	sample size was 18	residents.		1	4		
1	Abbreviations	N			1		
		ental Status			1		
1		tomy tube		1	i		
		lectrocardiogram			- 1		
	NP - Nurse Pra			l .	- 1		
	BID - Twice-a-day				- 1		
	EMS- Emergency Medical Services (911)				- 1		
	HVAC - Heating Ve	entilation/Air conditioning		ŀ	ľ		
	Neuro - Neurolog						
	B/P - Blood Pre						
- 1	CHF - Commun	nity Residential Facility					
	CNA- Certified N DMH - Departme				i		
	Peg tube - Percutan	ent of Mental Health					
	Gastrostomy	eous Endoscopic		*			
	NP - Nurse Pra	actitioner					
	L- Liter						
	DI - Deciliter	1				-	
- 10	CMS - Centers for Medicare and Medicaid Services			II.			
1:				l .			
		unit of mass)				A)	
		Administration Record		1			
	MD- Medical D			1			
	MDS- Minimum I			1			
		(metric system unit of mass) (metric system measure of			1		
	rolume)	menic system measure or					
	ng/dl - Milligrams p	per Deciliter					
Į,	nm/Hg- Millimeters	of Mercury				1	
F	POCT - Point of Co	entact				1	
		's Order Sheet					
				l	1		
BORATORY	DIRECTOR'S OR PROVIDE	RYSUPPLIER REPRESENTATIVE'S SIGNA	TURE	TITLE		6) DATE	

ROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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.

	OF DEFICIENCIES	MEDICAID SERVICES			OI	MB NO	0938-039
AND PLAN	OF CORRECTION	(X1) PROVIDERISUPPLIERICLIA IDENTIFICATION NUMBER:			STRUCTION NG	(X3) DA	TE SURVEY
		095039	B. WING				С
NAME OF	PROVIDER OR SUPPLIER	333003	D. WING	CTDEET		01	/03/2018
	ACCOUNT SECRETARIES		- 1		ADDRESS, CITY, STATE, ZIP CODE		
UNITED	MEDICAL NURSING H	OME			OUTHERN AVENUE, SE, SUITE 200 NGTON, DC 20032		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		WASHII			
PREFIX TAG	(EACH DEFICIENCY)	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	c	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	Continued From page	ge 1	F 00	00			
	Prn- As neede	ed	1				
- 1	Pt- Patient	-					
	TAR- Treatment	Administration Record					
	PASRR - Preadmiss	sion Screen and Resident		1			į.
	Review					55	
	ARD - Assessme IDT- Interdiscipli	nt Reference Date		1			1
	ID- Intellectua	inary Team					
t		licator Survey		1			1
	D.C District of						
- 1	D/C- Discontinue						
	Rp, R/P- Responsible	e Party PO-					
	By Mouth						l
F 456	ESSENTIAL EQUIPN CONDITION	MENT, SAFE OPERATING	F 45	6 1	An investigation was condu	ıctad	0/4/17
	CONDITION CFR(s): 483.90(d)(2)	(a)	1		Two employees were discip		
	or 11(0): 400.80(d)(2)	(e)		1	as a result of investigation		9/0/17
10	(d)(2) Maintain all me	chanical, electrical, and		1	according to policy.	aliu	
1	patient care equipme	nt in safe operating		1	according to policy.		
	condition.	. 5			Darida de Cara		0.10 = 11 =
- 1					Resident #1 was transferred		8/25/17
	(e) Resident Rooms	Emercal Construction of the Construction of th			the ED immediately where	he	
-	or adequate pursing	be designed and equipped care, comfort, and privacy of			was pronounced.		
	esidents.	care, connort, and privacy of					
100		is not met as evidenced		2.	No other resident was found	to	
t	y:			1	have been affected by this	1	
7 1	Based on record revi	ew and staff interviews, it			deficient practice. The medi		
W	as determined that f	acility staff failed to maintain			records of all residents with	a	
a	t least one (1) of thre	e (3) glucometers to be			diabetes diagnosis and order	s for	1/7/18
tr	nmediately available	ror emergency use.		1	blood sugar monitoring have		esta Februaria
+	he findings include:				been identified.		
A	ccording to the facilit	y's policy, "Accu-Chek					
[10	iform II Glucose Mete	er Test Procedure," POCT			All accu-check monitors we	-	17/10
12	2.1, last reviewed Jur	ne 28, 2017, the following		l		17	1/7/18
W	as noted on page 13	of 15: "Quality Control			calibrated, serviced and suppostocked	plies	

STATEMEN	IT OF DEFICIENCIES	CALL SECTION OF THE PROPERTY O		C	MB NC	<u>) 0938-039</u>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDERISUPPLIER/ IDENTIFICATION NUMBER (X1) PROVIDERISUPPLIER/ IDENTIFICATION NUMBER (X1) PROVIDERISUPPLIER/ IDENTIFICATION NUMBER (X1) PROVIDERISUPPLIER/ IDENTIFICATION NUMBER (X2) PROVIDERISUPPLIER/ IDENTIFICATION NUMBER (X3) PROVIDERISUPPLIER/ IDENTIFICATION NUMBER (X4) PROVIDERISUPPLIER/ IDENTIFICATION NUMBER (X5) PROVIDERISUPPLIER/ IDENTIFICATION NUMBER (X6) PROVIDERISUPPLIER/ IDENTIFICATION NUMBER (X7) PROVIDERISUPPLIER			1	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		095039	B. WING			С
NAME OF	PROVIDER OR SUPPLIER			CTDCCT ADDCCC	01	/03/2018
UNITED	MEDICAL NURSING H			STREET ADDRESS, CITY, STATE, ZIP CODE 1310 SOUTHERN AVENUE, SE, SUITE 200 WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(XS) COMPLETION DATE
F456	(QC) Testing: The foreach new day of test procedure performant specimen. a. The assigned nor solutions will be tested	illowing will be performed on ting to confirm the test nce before testing any patient mal and abnormal control	F 45	6 3. To prevent future occurrences a ensure availability for emergency one Glucose Meter has been ident (labeled), on each unit and will be recalibrated at 1:00am daily.	use, iified	1/16/18
	their pre-established testing can be perfor c. The QC reagents to be recorded on the G Log that is stored in to Notebook" On August 25, 2017 Resident #2 requeste	ranges before any patient med. with other information must flucose Meter Multi-Task QC he department POCT QC at approximately 4:45AM.		All licensed nursing staff will be educated on the "Accu-Chek Information Glucose Meter Test Procedure", to include the Quality (QC) Testing calibration, to ensure compliance. The night shift nursing supervisor be responsible for ensuring nightly	m II	Ongoing
	#1)." Facility staff attorequired incontinent of subsequently slid offine required four (4) staff back in bed. At that tirunresponsive. Facility and Employee #4 tool was initiated and the responsion of the resp	ended to Resident #1, who		4. Audits of Glucose Meter Daily logs will be conducted by the Unit Manager/designee daily and added nursing quality indicator to ensure compliance until three consecutive months of greater than or equal to compliance is achieved. Results of	unit. Test as a	Ongoing
r s l t a c E	'At about 4:42AM on a com 7048 came to the stated that "my roomn was the only one visione time because the cand the CNAs were at called the charge nursemployee #5 and told esident in room 7048 de/she now called the	e #4's written statement, B/25/17, the resident in e nursing station and nate needs to be changed." ble at the nursing station at other two charge nurses the back nursing station. I e who had that assignment him/her that his/her need to be changed. CNA and they both went to nt did the charge nurse or		audits will be provided to the DON will present at the quarterly Quality Assurance committee meeting. The QAC will ensure oversight and correction of any identified deficients. Corrective action completion date: 1/16/18	who y e	

1	STATEMENT OF PROPERTY	THE WINED TO AID OF TATOES			OMB N	O 0938-0391
l	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIERICLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		ATE SURVEY DMPLETED
		095039	B. WING			C 1/03/2018
ı	NAME OF PROVIDER OR SUPPL	ER	·	STREET ADDRESS, CITY, STATE, ZIP CODE		1/03/2010
L	UNITED MEDICAL NURSIN			1310 SOUTHERN AVENUE, SE, SUITE 200 WASHINGTON, DC 20032		
	PREFIX (EACH DEFICI	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(XS) COMPLETION DATE
	resident was in a needed to be che for injuries, no a any acute distremurses back to have need to get get the glucomer resident. I tried the was not able to thave not been cannot be encay one of the meter sugar. The chargethe resident at the and the resident at the and the resident A telephone inter 27, 2017 at 9:40, the use of the glucomer of the	ant to the resident say that the distress other than resident angedResident was assessed oparent injuries noted, was not in as, was lifted off the floor by four is/her bed. Itold the nurse that his/her vital signs while I went to der to do finger stick on the aree different glucometers but use anyone of them because they dibrated. I ended up calibrating to before I could check his/her are nurse and the CNAwas with the time providing care to him/her was not in any acute distress" with was not in any acute distress" And with Employee #4 regarding cometers on August 25, 2017 at stated, "The glucometers have fiter midnight every night. They wise. It is built into the machine. Calibrated right before the gars (6:00AM). That night I tried meters and they had not been night shift yet. I calibrated one of build use it to test Resident #1's she is a diabetic. Ittook me two maybe less. The meters were were just not calibrated." It to maintain at least one (1) of ters to be immediately gency use.	F 456			

CENTERS FOR MEDICARE & MEDICAID SERVICES						PRINTED: 01/05/2018 FORM APPROVED OMS NO 0938-0391		
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		095039	B WING	2 1		C		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	0	1/03/2018		
UNITED	MEDICAL NURSING H	IOME		1310 SOUTHERN AVENUE, SE, SUITE : WASHINGTON, DC 20032				
(X4) ID PREFIX TAG	(EACH DEFICIENCY I	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE X (EACH CORRECTIVE ACTION SH	OULD BE	(X5) COMPLETION DATE		
F 456	Continued From pag 2017.	ge 4	F4	456				
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