

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

PRINTED: 01/06/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185118	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 12/15/2010
NAME OF PROVIDER OR SUPPLIER  WOODLAND TERRACE HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1117 WOODLAND DRIVE ELIZABETHTOWN, KY 42701	
(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  AMENDED SOD 01/06/11  An abbreviated complaint survey (KY#15729) and follow up revisit to the annual health survey was conducted on 12/14/10-12/15/10. Immediate Jeopardy was determined to exist on 12/13/10 in 42 CFR 483.25 (F323 S/S "J") resulting in substandard quality of care. After quality review it was determined Immediate Jeopardy was removed and the facility remained in non-compliance at 42 CFR 483.25 (F323) deficiency remained at a S/S "D". In addition, the follow up revisit for the annual health survey completed 10/28/10 determined that all cited deficiencies had been corrected (483.15 F253 S/S "E", 483.20 F279 S/S "E", 482.25 F309 S/S "G", F334 S/S "D", 483.60 F431 S/S "D", and 483.65 F441 S/S "D").	F 000	<i>This Plan of Correction is the center's credible allegation of compliance.</i>  <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	Allege Compliance Date: 12/23/10
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to provide adequate supervision to prevent accidents for one resident (#8) of four sampled residents. (#8, #9, #10, and #11). The facility failed to follow the "Elopement Policy". These	F 323	I. Resident #8 returned to the facility at 3:30am on 12/13/10 and the facility initiated one to one supervision. A head to toe assessment was completed by the licensed nurse on Resident #8 at that time. The licensed nurse applied a wanderguard to Resident #8's lower extremity and another wanderguard remained in use on the wheelchair of Resident #8. Resident #8 was reassessed by a licensed nurse for wandering/elopement risk and the care plan was updated to reflect the elopement and interventions to prevent elopement. Resident #8 was placed on Q shift charting for 72 hours (completed 12/16/10).  The licensed nurse assigned a staff member to monitor the affected door immediately upon identifying the malfunction at approximately 12:40 am. The maintenance director arrived onsite at 1:30 am and verified all doors operational except for the rear north exit door. Vanguard Door security systems was notified and a technician arrived onsite at 4:50 am and corrected the situation. A reconfiguration of the door system was suggested by the technician and the manufacturer of the door system verified this would prevent the malfunction from reoccurring. This reconfiguration was completed at 2:30 pm on 12/13/10.	

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

TITLE

(X6) DATE

*[Signature]*

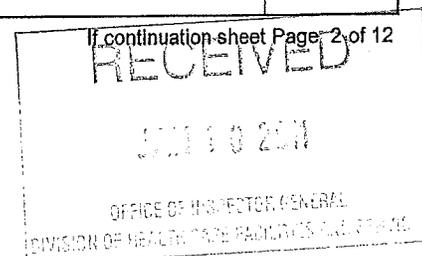
*X Administrator 1/7/11*

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.

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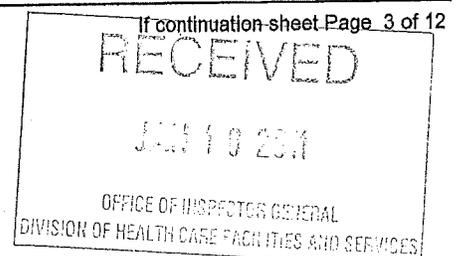
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NAME OF PROVIDER OR SUPPLIER  <b>WOODLAND TERRACE HEALTH CARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1117 WOODLAND DRIVE ELIZABETHTOWN, KY 42701</b>	
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F 323	<p>Continued From page 1</p> <p>failures resulted in Resident #8, who the facility assessed as at risk for elopement, exited the facility without staff knowledge. The resident was successful in ambulating approximately three tenths of a mile, in 15 degree weather, in the snow, wearing socked feet to a local hospital emergency room. The resident sustained minor scrapes to both knees during the elopement. The facility failure to provide supervision and appropriate assistive devices placed residents at risk for serious injury, harm, impairment or death.</p> <p>The findings include:</p> <p>Review of the "Elopement Policy" and "Wandering Resident Bracelet Testing" revealed the Licensed Nurse should: 1. Assess resident for risk and/or identify residents with a current history of elopement; 2. If resident at risk and/or has a history of elopement, place a wandering resident bracelet/device on the resident.</p> <p>Review of medical record revealed the facility admitted Resident #8 on 09/14/09 with diagnoses which included; Paranoid Schizophrenia, Dementia, and Post Traumatic Stress Syndrome (PTSS from a past Vietnam tour), and Chronic Obstructive Pulmonary Disease. Review of admission assessment history revealed the resident had previously eloped while at home prior to admission to the facility. The resident had been assessed as being confused and unable to accurately recall events. The facility developed a care plan on 09/02/09 which assessed Resident #8 as being at risk for wandering and elopement related to impaired safety awareness, disorientation to place, and schizophrenia. Review of the 08/23/10 Annual Minimum Data Set (MDS) Assessment revealed the facility had</p>	F 323	<p>II. The licensed staff reviewed all residents in the facility that had been identified as high risk for elopement. These residents were reassessed by a licensed nurse for elopement risk and their care plans were updated to reflect this risk with interventions to prevent elopement. These residents care plans, treatment administration records, and CNA assignment sheets were updated by a licensed nurse to include specific placement of wanderguard relative to resident body.</p> <p>The licensed nurse assigned staff members to validate proper function of the 8 facility doors immediately after being notified of the elopement. The maintenance director arrived onsite at 1:30am and verified all doors operational except for the rear north exit door. Vanguard Door security technician arrived at the facility and verified all doors operational at 4:50 am on 12/13/10.</p> <p>III. All current facility staff were trained on the facility policy on Wandering and Elopement. This training was initiated by the Executive Director on 12/13/10. Training continued by the Staff Development Coordinator until all active facility staff had been trained (completed 12/22/10).</p>	



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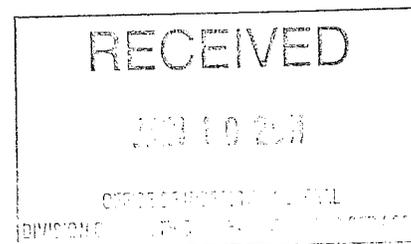
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F 323	Continued From page 2 assessed and determined the resident was independent with minimal assist for ambulation; however, had an unsteady gait. Review of the annual RAPS (resident assessment protocol summary) dated 08/30/10 revealed the facility had assessed and determined Resident #8 had triggered for cognition and mood with short and long term memory problems and Dementia with mood disorders. The RAP summary also detailed the resident was at risk for declining progressive dementia. The Mood RAP detailed the resident was identified as having persistent anger, sad worried facial expressions. Review of the last elopement assessment dated 11/16/10 identified Resident #8 at risk for elopement with the following care plan interventions: 1. Picture on Adventure Club; 2. Check wander guard placement at night; 3. Check wander guard placement every shift; 4. Redirect to sit down in chair when agitated and; 5. Offer diversional activity of interest such as music, small group activity.  Review of the facility investigation dated 12/14/10 revealed Resident #8 wanders, has a history of elopement with impaired decision making skills that decrease safety awareness. The resident was last seen in the North Lobby at 12:05 a.m. on 12/13/10. The facility was notified by the local hospital emergency room at 12:26 a.m. on 12/13/10 that the resident had arrived at the Emergency Room, clothed wearing pants, a shirt, a jacket and socks. There was no evidence that resident had the wander guard bracelet applied to his/her person. The investigative report detailed fifteen (15) staff members who were unaware the resident was missing, having not witnessed the incident or hearing any alarms from any exit doors. The investigation detailed that Resident	F 323	A reconfiguration of the door system was suggested by the technician and the manufacturer of the door system verified this would prevent the malfunction from reoccurring. This reconfiguration was completed at 2:30 pm on 12/13/10.  The maintenance director revised the preventative maintenance system for frequency of door monitoring by initiating twice daily door function checks for all facility doors on 12/13/10 and by having licensed staff initiate door function audits every 2 hours between the hours of 1600-0700.  The Treatment Administration Records for all current residents with wanderguards were updated by licensed staff to include the location of the bracelet. Placement will be verified every shift by the licensed nurses. Licensed nurses will be responsible to include the location on any new physician orders for wanderguards.  IV. The maintenance director will be responsible for tracking and trending the findings of the door function audits and reporting the data to the monthly Performance Improvement Committee. The Performance Improvement Committee may change the frequency of the audits based on the findings.	



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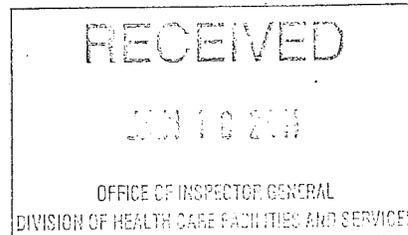
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F 323	Continued From page 3 #8 exited the building through the north back entrance.  On 12/15/10 at 8:35 a.m., LPN #2 revealed the resident had been agitated earlier in the evening around 7:30 p.m. screaming and yelling, "Santa Claus is a crook" and "Santa Claus shot me". LPN #2 stated the staff administered Haldol for agitation to Resident #8. The LPN stated the resident was calmer by 8:30pm and was eating pizza in the lobby and watching television. LPN #2 revealed that staff usually kept him/her at the nurse's station most evenings until he/she became tired; the LPN also stated the resident had behaviors and would run up and down the hall yelling at times; however, that night the resident just sat in his/her wheelchair at the nurses station/lobby. LPN #2 stated the resident was last seen in the north lobby at 12:05 a.m. on 12/13/10. She revealed the medication delivery came around midnight at which time she was checking in the medications with her back to the north hallway making her unaware of Resident #8 exiting the building. She stated the hospital reported to her that the resident arrived in the Emergency Room at 12:26 a.m. and told them where he/she lived (Woodland Terrace); she stated the resident's name was labeled on his/her clothing for identification. LPN #2 also revealed the resident told her he/she ran all the way to the hospital because he/she was sick. The resident also told her that he/she fell on the way and scraped both knees. The LPN #2 revealed the facility assessment of Resident #8 upon his/her return to the facility identified the resident sustained scrapes to both knees.  On 12/15/10 at 8:00 a.m., CNA #1 confirmed that Resident #8 had been last seen around 12:05	F 323	The Director of Nursing will be responsible for reporting a monthly review to the Performance Improvement Committee of all residents identified to be at risk for elopement. This review will include placement of the wanderguards, physicians orders for wanderguard, and care plan interventions to prevent elopement.	



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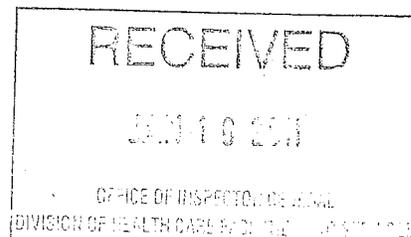
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F 323	<p>Continued From page 4</p> <p>a.m. on 12/13/10 in the lobby and revealed she was responsible for Resident #8 that night. CNA #1 revealed she made bed check rounds around midnight; however, there were two residents reported to need assistance which pulled her away from the north hall rear exit. She also stated the other CNA was on the front hall in a room with another resident and would not have been able to see Resident #8 leave through the rear north door. CNA #1 stated she would not have seen Resident #8 exit the building; she also revealed she did not know the resident was gone until the hospital called. She was assigned to check the doors after they were aware of Resident #8's elopement at which time she identified the rear north hall door was unlocked and opened without alarming. CNA #1 stated that Resident #8's room had only his/her wheelchair with the wander guard still attached to the wheelchair.</p> <p>Review of the investigative report dated 12/14/10 revealed CNA #6, who also worked on the north hall on 12/13/10 night shift revealed she remembered Resident #8 sitting in the lobby in the wheelchair, and noted that the resident had predominately been mobile in the wheelchair.</p> <p>Interview with the Maintenance Director, on 12/14/10 at 6:30 p.m., and review of the door system information in the investigative report revealed he checks door security systems weekly by using a maintenance task sheet. The task sheet includes verifying magnetic door switches intact, alarm buzzers functioning, keypads functional, wire connections secure, magnetic locks secure and aligned properly, system sounds alarm after 3 seconds of continuous pressure to door or panic hardware, and alarm sounds if magnetic lock does not engage. Review of the</p>	F 323		



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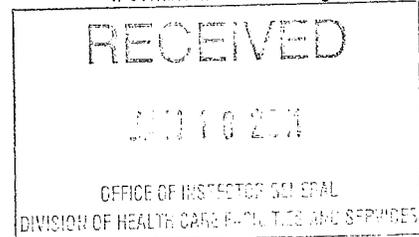
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F 323	Continued From page 5 task sheets revealed that all the facility doors, including the north rear door, were checked and verified to work properly on 12/03/10 and 12/10/10. Further review of the investigation revealed the wander guard system is checked for function every night for all residents identified as at risk for elopement. The check was completed around 9:00 p.m. on 12/12/10 and the door was functioning properly at approximately 10:00 p.m. when another staff member exited the door using the code. Further review of the investigative report revealed that all doors were checked to ensure proper operation by licensed nurses at which time the north rear enxit was identified as malfunctioning. The report stated magnets were not engaging to ensure proper door closure. While the facility completed all the door and alarm checks as per their policy, there was no evidence that the facility ensured they were following their Elopement policy by applying the wander guard bracelet to the resident as it was only applied to the resident's wheelchair. Furthermore, despite the efforts of the facility's use of assistive devices (i.e. wander guard and door alarms), the facility did not ensure staff supervised the resident to prevent elopement. Thus resulting in Resident #8 successfully exiting the facility without staff knowledge.  Further review of the investigative report and interview with the Administrator, on 12/14/10 at 8:30 p.m., revealed the facility took the following immediate action: 1. A head count for the entire facility by licensed nurses completed at 12:40 a.m. on 12/13/10, and all residents were accounted. 2. Resident's at risk for elopement were checked for proper wander guard placement, verified functioning of all wander guard bracelets and	F 323		



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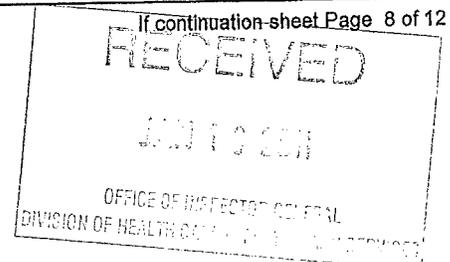
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F 323	Continued From page 6 increased monitoring was initiated on all wander risks. 3. LPN #2 immediately positioned a staff person to monitor the door monitor and ensure all residents' safety until the doors could be repaired. 4. The Maintenance Director arrived at 1:30 a.m. and verified all doors operational except for the rear north exit door. 5. The Administrator arrived at 2:15 a.m. and completed education of policy and procedure, related to Elopement/Missing Resident for all staff on site at approximately 5:00 a.m. 6. The facility notified the Van guard representative at 2:45 a.m. regarding the door malfunction. Van guard arrived on site at 4:50 a.m. Vanguard Alarm System technician arrived and corrected the situation. Reported that these systems are low voltage systems and are susceptible to power disturbances or a weather disturbance, which could lead to the system resetting itself back to default mode (in default mode the system does not actively lock the door or alarm when they are opened). This was verified with RF technologies, the manufacturer of the door system, who suggested a reconfiguration of the system, which was completed at 2:30 p.m. by Vanguard on 12/13/10. In addition, the report determined the system of preventative maintenance was in place for ensuring door security and facility monitors the door system weekly per the preventative maintenance program. The system for preventative maintenance on the wander guards is that they are checked daily by the licensed nurses for proper functioning. 7. Interview with the Director of Nursing (DON) on 12/14/10 revealed Resident #8 returned to the facility at 3:30 a.m. on 12/13/10 and the facility initiated one to one supervision for Resident #8.	F 323			



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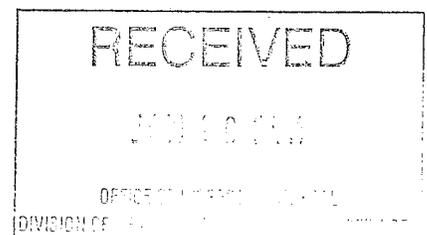
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F 323	<p>Continued From page 7</p> <p>A head to toe assessment was completed on resident #8 confirming scrapes to both knees with no complaints of pain. The facility applied a wander guard to Resident #8's lower extremity and maintained the wander guard to the resident's wheelchair. Both wander guards are checked daily for function, although the resident did have a history of removing medical devices, or injury and a nursing assessment was performed by the hospital and the facility upon arrival. The DON also revealed the care plan included interventions for behavior episodes which have been successfully implemented to redirect resident and alleviate behaviors. Interventions have been implemented to address the elopement risk of the resident.</p> <p>Observation of Resident #8 on 12/14/10 at 7:30 p.m. revealed the resident lying in bed with Oxygen at 2 liters per nasal cannula and sleeping. The resident had the wander guard bracelet applied to his/her lower extremity. CNA #3 was observed sitting with resident #8 for one to one supervision. Interview with CNA #3, at 7:30 p.m. revealed the resident had exhibited no further attempts at elopement and there had been someone sitting with the resident since the resident returned to the facility.</p> <p>Review of the clinical record for Resident's #9, #10, and #11 on 12/14 - 12/15/10 revealed the residents had been assessed for risk of elopement and had wander guard bracelets. Resident #10 was admitted on 10/07/10 and had a past history of wandering and was on every 15 minutes checks to include checking for placement of the wander guard. Resident #9 was newly admitted on 11/08/10 and had been assessed as an elopement risk due to constantly standing by</p>	F 323		



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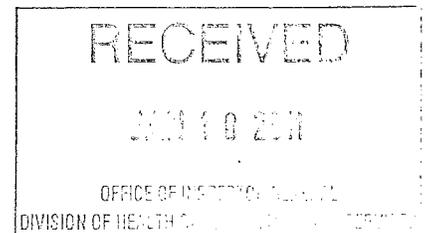
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F 323	<p>Continued From page 8</p> <p>the doors and talking about needing to get the car keys to drive home. Resident #9 was observed by therapy on 11/15/10 attempting to leave the facility. Staff intervened at which time the facility initiated one to one supervision of Resident #9. Interview with the Administrator revealed the resident was on the waiting list for placement in an Alzheimer Unit at the present time. Observation of Resident #9, on 12/14/10 at 7:30 p.m., revealed the resident was walking up and down the hallway with a staff member at the resident's side at all times.</p> <p>Interview with the Administrator on 12/15/10 at 2:30 p.m. and review of the investigative report regarding the Performance Improvement meeting revealed a Performance Improvement (PI) Meeting was held on 12/13/10 with the Administrator, Maintenance Director, Unit Manager, Social Services Director, Case Manager, Activities Director, Business Office Manager, and Admissions Coordinator in attendance. A separate PI meeting was also held with the Medical Director, who was involved with the incident, and could not be there at the time of the meeting; however signed the minutes to the meeting. The following additional measures were verified as completed prior to the state agency entrance into the facility:</p> <ul style="list-style-type: none"> <li>*Update Resident #8's care plan to reflect elopement</li> <li>*Update CNA assignment sheet to reflect 1:1 care</li> <li>*Update all care plans, treatment administration record and CNA assignment sheet to include specific placement of wander guard relative to resident body</li> <li>*Every shift charting for 72 hours on Resident #8</li> <li>*All residents identified at risk</li> </ul>	F 323		



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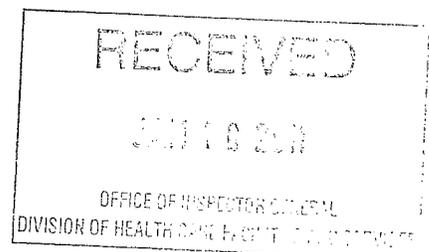
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185118	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 12/15/2010
NAME OF PROVIDER OR SUPPLIER  WOODLAND TERRACE HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1117 WOODLAND DRIVE ELIZABETHTOWN, KY 42701	
(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 323	<p>Continued From page 9</p> <p>elopement/wandering were reassessed. *Licensed Nurses had completed door function audit every 2 hours between 1600-0700. Continued checks of door function were assigned and scheduled for nursing services and Maintenance. *Validation of wander/elopement assessment complete and up to date pictures are located in the book. *Daily check to insure proper signage at each door for a period of one month *Vanguard arrived at facility successfully administered system reconfiguration. *Education was completed for all facility staff on 12/13/10 related to Elopement Procedures, Wander Guards. *Medical Director notified and reviewed PI Committe minutes on 12/13/10</p> <p>Interview with the Administrator on 12/15/10 at 2:30 p.m. revealed there had been no policy changes to the current elopement policy.</p> <p>Interviews with facility staff on 12/14/10 at 9:25 p.m., and 9:35 p.m.; LPN #1, RN#1, CNA's #2, #3, #4, and #5; on 12/15/10 at 8:00 a.m. and 8:35 a.m. CNA's # 1, and LPN #2 revealed they had been in-serviced on 12/13/10 on the elopement policy and procedure, proper functioning of the door alarm system and wander guard system. All staff was able to demonstrate the procedures.</p> <p>Door alarm checks with the Maintenance Director, on 12/14/10 at 7:30 p.m. and again on 12/15/10 at 9:00 a.m. revealed the north rear door was functioning properly as well as the wander guard system when residents with wander guards approached doors.</p>	F 323		



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F 323	Continued From page 10  Resident #8's medical record was reviewed on 12/14 - 12/15/10 to verify updates of the care plan regarding elopement, CNA assignment sheet, Treatment Administration Record to include specific placement of wander guard relative to the resident's body, and 72 hour charting. All residents identified at risk for elopement (9 residents) were reassessed. Door function audits were reviewed and validation of the updated pictures in the adventure club book. Proper signage was verified on all exit doors, and evidence of work order with Vanguard verified with copies for system configuration. Elopement, behavior, and wander guard in-services conducted on 12/13/10 were reviewed for all staff with a plan in place to educate weekend staff (roster sheet with date and next shift to be worked), which is to be completed by administration before coming back to work. Performance improvement minutes date, time, staff in attendance, and discussion of items covered was reviewed and verified staff signatures and dates.  The facility, after having investigated the incident, immediately implemented the elopement policy by conducting resident head counts, checked all doors and placed staff at the north rear door which was not functioning. After Resident #8 returned to the facility, the resident was assessed and placed on one to one supervision, and the wander guard was placed on the resident's person. All residents identified at risk for elopement were reassessed. Immediate training and education was conducted at 5:00 a.m. by the Administrator on elopement procedures, missing resident procedures, wander guard procedures, and door alarm systems. A QA meeting was held	F 323			



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NAME OF PROVIDER OR SUPPLIER  <b>WOODLAND TERRACE HEALTH CARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1117 WOODLAND DRIVE ELIZABETHTOWN, KY 42701</b>		
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F 323	Continued From page 11 on 12/13/10 with notification to the medical director to identify and assess corrective action for supervision and prevention of accidents.  Immediate Jeopardy was determined to exist on 12/13/10 in 42 CFR 483.25 (F323 S/S "J") resulting in substandard quality of care. After quality review it was determined Immediate Jeopardy was removed and the facility remained in non-compliance at 42 CFR 483.25 (F323) deficiency remained at a S/S "D".	F 323			

