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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: J28PXP

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 000338

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **155441**
2.STATE VENDOR OR MEDICAID NO.
(L2) **100287590**

3. NAME AND ADDRESS OF FACILITY
(L3) **CORYDON NURSING AND REHABILITATION CENTER**
(L4) **315 COUNTRY CLUB RD**
(L5) **CORYDON, IN** (L6) **47112**

4. TYPE OF ACTION: **9** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)

11. LTC PERIOD OF CERTIFICATION
From (a):
To (b):

12.Total Facility Beds **38** (L18)

13.Total Certified Beds **38** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A*** (L12)

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	38			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
SA recommends approval for a room size waiver for tag F458 cited at the 8/20/14 Health Survey

17. SURVEYOR SIGNATURE Date: (L19)

18. STATE SURVEY AGENCY APPROVAL Date: Matt Callin 10/07/2014 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible (L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **00000** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

SURVEYOR VARIANCE EVALUATION AND RECOMMENDATION FOR APPROVAL

State Form 50816 (2-02)
Indiana State Department of Health-Division of Long Term Care

000338 155441
CORYDON NURSING AND REHABILITATION CEN
315 COUNTRY CLUB RD
CORYDON, IN 47112-9281

During the survey on 8-20-14 ***, the following rooms were cited as indicated:***

☐ ***Tag #457*** - More than four (4) beds per room.

Room Number(s): _____

☒ ***Tag #458*** - Less than eighty (80) square feet per bed in multiple bed room and less than one hundred (100) square feet in single rooms.

Room Number(s): 11

I RECOMMEND THAT THE VARIANCE FOR THE ABOVE REFERENCED ROOM(S) BE GRANTED.

The survey team has determined that the existing arrangements in the designated rooms provided efficient space **to meet resident needs** (i.e. privacy, adequate space for nursing services, and space for residents to get in and out of wheelchairs, etc). There seems to be no adverse affect on resident health and safety, provided the facility performs their duties appropriately..

Surveyor Signature: _____ Date: _____

Surveyor Name *(print or type)*: _____

Supervisor Signature: Brenda Brown Date: 10/7/14

Supervisor Name *(print or type)*: _____

Indiana State Department of Health
An Equal Opportunity Employer

Michael R. Pence
Governor

William C. VanNess II, MD
State Health Commissioner

155441
100287590
000338

October 7, 2014

Jessica Money

Corydon Nursing And Rehabilitation Center
315 Country Club Rd
Corydon, IN 47112-9281

Re: Waiver of 42 CFR 483.70(d)(1)(ii) Physical Environment

Dear Jessica Money:

This letter is to confirm receipt by the Division of Long Term Care ("Division") of the facility's request for a room size waiver for SNF/NF room(s) 11 cited at federal tag F458 at the August 20, 2014 Recertification and State Licensure Survey.

The Division is forwarding the facility's request to the Centers for Medicare and Medicaid Services ("CMS") with a recommendation for approval of a waiver.

Do not hesitate to contact me at 317/234-3071 should you have questions regarding this matter.

Sincerely,

Miles Collins MBA
Enforcement Coordinator
Division of Long Term Care

cc: Area Supervisor
Public File
CMS
Enforcement Manager