

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366488	(X2) MULTIPLE CONSTRUCTION a. building _____ b. wing _____	(X3) DATE SURVEY COMPLETED 12/05/2019	
NAME OF PROVIDER OR SUPPLIER NEW AVENUES-PERRY		STREET ADDRESS, CITY, STATE, ZIP CODE 5051 SOUTH RIDGE RD PERRY OH, 44081		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETION DATE
W 0000	<p>INITIAL COMMENTS</p> <p>FUNDAMENTAL SURVEY</p> <p>ADMINISTRATOR: Karen Knavel CERTIFIED BED CAPACITY: 8 CENSUS IN HOUSE: 7</p> <p>At the time of the Fundamental survey completed on 12/05/19, New Avenues - Perry is in compliance with the provisions of 42 CFR Part 483, Subpart I, Requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities, excluding the Life Safety Code.</p>	W 0000		

laboratory director's or provider/supplier representative's signature

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.