STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185145	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Ridge Health Campus	**1217 US Highway 62 E , Cynthiana, Kentucky, 41031**

(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
F0000	INITIAL COMMENTS Based upon the off-site Revisit Survey and implementation of the acceptable Plan of Correction received via ePOC on 02/19/2026, the facility was deemed to be in compliance on 02/18/2026, as alleged.	F0000		02/20/2026

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

Kentucky State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100751	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Ridge Health Campus	**1217 US Highway 62 E , Cynthiana, Kentucky, 41031**

(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
N0000	Initial Comments Based upon the off-site Revisit Survey and implementation of the acceptable Plan of Correction received via ePOC on 02/19/2026, the facility was deemed to be in compliance on 02/18/2026, as alleged.	N0000		02/20/2026

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185145	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - CEDAR RIDGE HEA.. B. WING	(X3) DATE SURVEY COMPLETED 01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Ridge Health Campus	1217 US Highway 62 E , Cynthiana, Kentucky, 41031

(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
K0000 Bldg. 02	INITIAL COMMENTS 42 CFR 483.90(a) K3 BUILDING: 0101 K6 PLAN APPROVAL: 2004, 2016 K7 SURVEY UNDER: 2012 Existing K8 SNF/NF Type of Structure: One (1) story (2004,2016) Type V (111), protected combustible construction with seven (7) smoke compartments and a complete automatic dry sprinkler system. A Life Safety Code Recertification Survey was initiated on 01/21/2026 and concluded on 01/21/2026 in accordance with 42 Code of Federal Regulations, Part 483:90(a) Requirements for Long Term Care Facilities. During this Recertification Survey, Cedar Ridge Health Campus was found to be in compliance with the Requirements for Participation in Medicare and Medicaid.	K0000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185145	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E0000	Initial Comments 42 CFR 483.73 Type of Structure: One (1) story (2004, 2016), Type V (111), protected combustible construction with seven (7) smoke compartments and a complete automatic dry sprinkler system. An Emergency Preparedness Recertification Survey was conducted on 01/21/2026, in accordance with 42 Code of Federal Regulations, Subpart 483.73 (a)(3): (emergency preparedness) Requirements for Long Term Care Facilities. During this Recertification Survey, Cedar Ridge Health Campus was found to be in compliance with the Requirements for Participation in Medicare and Medicaid.	E0000		

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185145	A. BUILDING B. WING	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0000	INITIAL COMMENTS A Recertification and Abbreviated Survey was concluded on 01/22/2026. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. No deficiencies were issued related to 2581337. Survey Dates: 01/19/2026 to 01/22/2026 Survey Census: 53 Sample Size: 35	F0000		02/11/2026
F0583 SS = D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of	F0583	F583 Privacy and Confidentiality Corrective actions for the identified resident affected by the deficient practice. A care plan meeting was conducted on 02/11/26 with resident 3's and his daughter. This meeting discussed the use of the non-recording video monitor as a fall intervention. A consent was signed by the resident's daughter, POA allowing the use of the non-recording video monitor. A verbal consent was obtained and witnessed on 01/21/26 and scanned into his clinical record. Identification of other residents who may be affected by the deficient practice and corrective actions that will be put in place to ensure the deficient practice does not recur. All residents have the right to privacy. Resident 3 resides in a private room. The facility does not have any other residents who utilized a non-recording video monitor. There are no other monitors in resident rooms. Measures put in place and systemic changes you will make to ensure that the deficient practice does not recur. Prior to implementing an intervention such a non-recording video monitor the facility will conduct a care plan meeting with the resident and/ family/RP explaining the use of the device. This meeting will include the facility's interdisciplinary team which includes the DHS, ADHS, MDS, Social Services and Life enrichment. If the resident and or family agree to the non-recording video monitor for the purpose of falls intervention, a consent will be signed and placed in	02/18/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185145	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/22/2026

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Cedar Ridge Health Campus	**1217 US Highway 62 E , Cynthiana, Kentucky, 41031**

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F0583 SS = D	Continued from page 1 personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure the resident's right to privacy by allowing a video camera to be installed, which actively monitored a resident's room without documented consent or adherence to facility policy for 1 of 2 residents reviewed for dignity, Resident (R) 3. The findings include: Review of the facility's policy titled, "Resident Electronic Monitoring SOP [Standard Operating Procedure]," undated, revealed, "The resident, attorney-in-fact, or guardian must authorize the installation and use of the device for remote monitoring on our standard authorization form. The campus must prior approve any electronic monitoring devices to make sure that they are the type allowable by law, and only facility personnel may install the devices after they have been approved. We may post notices in and outside the resident's room that electronic monitoring is in use." Review of the facility's policy titled, "Resident Rights Guidelines," revised 05/11/2017, revealed, "Our residents have a right to: a. Be treated with dignity and respect" and "d. Privacy." Review of R3's "Admission Record" revealed the facility admitted the resident on 01/04/2025 with diagnoses of heart disease, acute kidney failure, atrial fibrillation, malnutrition, diabetes mellitus, and dementia. Review of R3's annual "Minimum Data Assessment [MDS]," with an Assessment Reference Date (ARD) of 11/14/2025, revealed the facility assessed the resident to have a "Brief Interview for Mental Status [BIMS]" score of 11 of 15, indicating R3 had moderate cognitive impairment. Review of R3's "Care Plan" included a problem statement initiated on 01/04/2025 that indicated the resident was at risk for falls related to weakness and impaired	F0583	Continued from page 1 the resident's medical record. Describe the Quality Assurance and Process Improvement Program that will be put in place. An Ad Hoc Quality Assurance meeting was convened on 02/11/26 with the Medical Director to discuss the concern identified related to privacy utilizing a non-recording video monitor. Starting on 02/16/26 a Quality Assurance meeting will be held weekly for four weeks, then monthly for recommendations and further follow-up regarding the above stated plan. Starting on 02/16/26 an audit will be conducted daily during morning meeting by the DHS/ADHS to ensure no additional non-recording video devices have been implemented. Beginning 2/17/26, the SSD will observe resident 3 daily for 2 weeks to ensure he has not declined psychosocially due to the use of the non-recording video monitor, then weekly for 4 weeks and then monthly for 2 months. Any concerns will be discussed with the interdisciplinary team and discontinuation of the device will be considered. The Social Service Director will report the findings of the observations to the monthly QAPI Committee. The Committee will determine the ongoing frequency of the observations. Daily reviews will be ongoing by the DHS/ADHS during morning meeting. The Administrator has the oversight to ensure an effective plan is in place to meet the residents' well-being as well as an effective plan to identify facility concerns and implement a plan of correction. Members of the QAPI committee include Medical Director, Administrator, DHS, ADHS, Social Services, Plant operations, dietary and life enrichment. 02/18/26	

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F0583 SS = D	Continued from page 2 balance. Interventions directed staff to monitor with a non-recording portable video camera (initiated 12/10/2025). During an observation on 01/19/2026 at 10:28 AM, a camera was observed mounted inside R3's room, positioned high on the wall to the left of the door, pointing directly at the bed. The monitor for the camera was located behind the nurses' station. During an observation on 01/20/2026 at 8:55 AM, the camera in R3's room was on, and the monitor was visible on the desk behind the nurses' station. During an observation on 01/21/2026 at 11:34 AM, the camera in R3's room remained in place, pointed toward the bed, with the unattended monitor active at the nurses' station. Review of R3's "Physician Order Report," for the timeframe of 12/20/2025 through 01/20/2026, revealed no orders for the use of the electronic monitoring device. Review of R3's medical record revealed no written consent was found for the use of the monitor/camera. The facility obtained verbal consent from R3's Power of Attorney (POA) during the survey on 01/21/2026. Attempts were made to contact R3's POA during the survey on 01/20/2026 at 6:21 PM, 01/21/2026 at 10:45 AM, and 01/22/2026 at 8:46 AM and 10:28 AM, to confirm that the use of the video monitor had been discussed and consent obtained. There was no response from the POA by the end of the survey on 01/22/2026. During an interview on 01/21/2026 at 1:27 PM, the Ombudsman stated she researched state law and found that cameras in resident rooms were not allowed, although there was conflicting information about audio consent. She stated that at a minimum, a policy and consent should be in place. During an interview on 01/22/2026 at 8:40 AM, the Director of Environmental Services stated at first, she had not obtained consent for anything for any resident, then she was the witness during a phone call to R3's POA the previous day (during the survey) for the camera. She stated she heard the POA say it was okay. During an interview on 01/22/2026 at 8:45 AM, the Director of Health Services (DHS) stated the facility obtained verbal consent the previous day because they did not realize they needed to obtain consent.	F0583		

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F0583 SS = D	Continued from page 3 During an interview on 01/22/2026 at 9:35 AM, Clinical Support Staff 5 stated it was a state law that the Executive Director (ED) had the right to request a camera in the facility. She stated it was a fixed monitoring device and not recording, and the ED gave verbal approval for it. During an interview on 01/22/2026 at 10:45 AM, Activities Staff 4 stated when the facility installed the camera, the staff was told to make sure it was turned off during personal care and whenever the resident was not in the room. During an interview on 01/22/2026 at 10:46 AM, Licensed Practical Nurse (LPN) 1 stated staff was told when the camera was installed, they needed to turn it off whenever personal care was being provided. LPN1 stated the monitor was on and sitting at the desk next to her. During a concurrent observation, LPN1 turned the monitor face down. She stated there was a button on the monitor to turn it off, or the staff could just unplug it when they were in the room. During an interview on 01/22/2026 at 11:35 AM, the Interim ED stated the facility had verbal consent from the POA prior to the use of the camera, but they were not sure it was documented. She stated they thought the consent to photograph included in the admission record covered it, and they had tried to contact the POA twice to confirm the consent, with no response.	F0583		
F0759 SS = D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, review of the manufacturer's instructions for use, and facility policy review, the facility failed to ensure a medication error rate of 5 percent (%) or less. Observation on 01/22/2026 revealed 2 errors administering insulin (given to lower blood sugar) out of 27 opportunities observed for correct medication administration, which yielded a medication error rate of 7.41%. The errors affected 2 of 5 residents observed	F0759	F759 Free of Medication Error Rates of 5% or More. Corrective actions for identified residents affected by the deficient practice. Resident 11 and 23 blood sugars for the last 30 days were reviewed on 02/11/26 by the Director of Health Services. Both residents remain at the facility with no adverse effects from medication error related to not priming insulin pens. Identification of other residents who may be affected by the deficient practice and corrective actions that will be put in place to ensure the deficient practice does not recur. All residents who receive insulin injections have the potential to be affected. The Director of Health Services completed an audit on 02/11/26 at Cedar Ridge Health Campus to ensure all residents who reside in the facility have had no adverse effects from medication error related to not priming insulin pens. Measures put in place and systemic changes you will	02/18/2026

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F0759 SS = D	Continued from page 4 for medication administration, Resident (R) 11 and R23. The findings include: Review of the facility's policy titled, "Medication Administration – General Guidelines," revised 11/2018, revealed, "Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so." Further review of the policy revealed, "4) FIVE RIGHTS – Right resident, right drug, right dose, right route and right time, are applied for each medication being administered. A triple check of these 5 Rights is recommended at three steps in the process of preparation of a medication for administration: (1) when the medication is selected, (2) when the dose is removed from the container, and finally (3) just after the dose is prepared and the medication put away." On 01/22/2026 at 1:25 PM, the Director of Health Services (DHS) stated the facility did not have a policy on insulin use. Review of the manufacturer's instructions for use in a document titled, "NovoLog® (insulin aspart) Injection Flex Pen Instructions for Use," revised 02/2023, revealed the section titled, "Giving the airshot before each injection," included, "Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing: E. Turn the dose selector to 2 units" and "F. Hold your Novolog FlexPen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge," then "G. Keep the needle pointing upwards press the push-button all the way in." Further review revealed, "The dose selector returns to 0. A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than 6 times." Review of R23's "Physician Order Report" revealed the facility admitted the resident on 12/28/2020 with diagnoses to include type 2 diabetes mellitus with hyperglycemia. Further review of active orders as of 01/22/2026 revealed an order dated 07/06/2025 for insulin aspart U-100 (rapid acting insulin with a concentration of 100 units per milliliter [ml]) insulin pen, with instructions to give per sliding scale (dose of insulin based upon the blood glucose level). 1. During an observation of medication administration on the 100 Hall on 01/22/2026 at 11:43 AM, Licensed Practical Nurse (LPN) 3 attached a needle to R23's	F0759	Continued from page 4 make to ensure that the deficient practice does not recur. On 01/22/26 Trilogy Health Services Campus Clinical Campus Support re-educated the Director of Health Services and Assistant Director of Health Services on medication procedures related to injectable medication via a insulin pen. Once trained, the Director of Health Services provided re-education to the nurses on medication administration procedures related to injectable medications via a insulin pen. On or before 02/13/26 the staff completed a posttest administered by the Director of Health Services, which required a 100% pass rate to verify retention of the provided education. After 02/13/26, any newly hired staff or anyone not trained before 2/13/26 will be educated through orientation or before working their shift by the DHS or ADHS with a post-test completed to ensure staff knowledge was retained on the above training material with a passing score of 100%. The campus does not use agency staff. Describe the Quality Assurance and Process Improvement program that will be put into place. An Ad Hoc Quality Assurance meeting was completed on 02/11/26 with the Medical Director to discuss the findings from the cited deficiency related to medication administration procedures related to injectable medication including use of insulin pens. Starting on 02/11/26 a Quality Assurance meeting will be held weekly for 4 weeks, then monthly for recommendations and further follow up regarding the above stated plan. Starting on 02/16/26. as part of the facility's ongoing quality improvement plan, the Director of Health services and or the Assistant Director of Health Services will observe a cumulative total of 5 five insulin injections, weekly for 4 weeks, then every other week for 4 weeks, then monthly times 1 month, to ensure staff administer insulin via a pen properly without error. The Director of Health Services and /or Assistant Director of Health Services will present the findings from the audits to the monthly QAPI committee. The committee consists of the Medical Director, Executive Director, DHS, ADHS, Social Services, Life enrichment, dietary and Plant operations. The QAPI committee will determine ongoing frequency of the monitoring plan based on the findings from the above-mentioned on-going audits. The Administrator has the oversight to ensure an effective plan is in place to meet the residents' well-being as well as an effective plan to identify facility concerns and implement a plan of correction. Facility alleges compliance on 02/18/2026.	

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F0759 SS = D	Continued from page 5 insulin aspart pen, turned the dose selector to ten units, and began to walk toward the resident. The State Survey Agency (SSA) Surveyor stopped LPN3 to confirm if she was ready to administer the insulin and asked about priming the pen. LPN3 stated she was not aware the needle needed to be primed prior to dialing the dose. Review of the manufacturer's instructions for use in a document titled, "Instructions for Use Humalog (Hu-ma-log) KwikPen (insulin lispro) injection," revised 07/2023, specified, "Prime before each injection. - Priming your Pen means removing the air from the Needle and Cartridge that may collect during normal use and ensures that the Pen is working correctly. - If you do not prime before each injection, you may get too much or too little insulin." Further review revealed, "Step 6: - To prime your Pen, turn the Dose Knob to select 2 units. Step 7: - Hold your Pen with the Needle pointing up. Tap the Cartridge Holder gently to collect air bubbles at the top. Step 8: Continue holding your Pen with Needle pointing up. Push the Dose Knob in until it stops, and [0] is seen in the Dose Window." Review of R11's "Physician Order Report" revealed the facility admitted the resident on 12/24/2025 with diagnoses to include type 2 diabetes mellitus with ketoacidosis without coma and type 2 diabetes mellitus with diabetic neuropathy, unspecified. Further review of active orders as of 01/22/2026 revealed an order dated 12/30/2025 for Humalog KwikPen Insulin (insulin lispro) insulin pen, with instructions to give five units three times a day with meals for diabetes. 2. During an observation of medication administration on the 200 Hall on 01/22/2026 at 11:55 AM, Registered Nurse (RN) 2 attached a needle to R11's Humalog KwikPen, turned the dose selector to 5 units, and began to walk toward the resident. The SSA Surveyor stopped RN2 to confirm if she was ready to administer the insulin and asked about priming the pen. RN2 stated, "Oh yeah, I am supposed to prime it with two units." During an interview on 01/22/2026 at 10:46 AM, LPN1 stated nurses should prime the insulin pen needle with two units prior to dialing in the dose to be administered to ensure the resident was getting the full amount ordered. During an interview on 01/22/2026 at 11:20 AM, the DHS stated nurses should follow the manufacturer's recommendations to prime the needle prior to use to ensure the full amount of insulin ordered was administered.	F0759		

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F0759 SS = D	Continued from page 6 During an interview on 01/22/2026 at 11:35 AM, the Interim Executive Director (ED) stated she expected the nurses to follow manufacturer guidelines with the use of insulin pens, and the medication error rate should be less than 5%.	F0759		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Ridge Health Campus	**1217 US Highway 62 E , Cynthiana, Kentucky, 41031**

(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
N0000	Initial Comments A Re-licensure and Complaint Survey was initiated on 01/19/2026 and concluded on 01/22/2026 with deficient practice cited. No deficiencies were issued related to 2581337. Survey Census: 53	N0000		02/11/2026

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE