STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255118	A. BUILDING _____ B. WING _____	03/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF MERIDIAN	4728 HIGHWAY 39 NORTH MERIDIAN, MS 39301

(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 CI# MS00015730 The State Agency (SA) conducted an annual recertification survey, along with complaint investigation (CI MS #15730), from 3/25/2019 through 3/28/2019. The SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation. The SA cited the regulatory deficiencies F623, F642, and F812. The result of the complaint investigation was unsubstantiated. The census at the time of survey was 80, and the facility held a license for 120 beds.	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or	F 623		5/4/19

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

Electronically Signed | 04/30/2019

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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F 623	Continued From page 1 discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual	F 623		

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F 623	Continued From page 2 and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review, facility policy review, and staff interview, the facility failed to issue a written notification of transfer to an acute care hospital to the Resident Representative (RR) for	F 623	This plan of correction constitutes Diversicare of Meridian credible allegation of compliance for the cited deficiencies. Nothing in this plan of correction should	

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F 623	Continued From page 3 five (5) of five (5) residents reviewed for hospitalizations: Resident #10, Resident #35, Resident #65, Resident #71, and Resident #79. Findings include: A review of the facility's policy titled, "Notification of Change in Patient/Resident Health Status," dated June 2017, revealed, the purpose was to ensure all interested parties are informed of the patient's/resident's change in health status, so that a treatment plan can be developed, which is in the best interest of the patient/resident. The process revealed, "The facility will consult the resident's physician, nurse practitioner or physician assistant, and if known notify the patient representative when there is: ...(D) A decision to transfer or discharge the resident from the center. Notification will be immediate. Definition: Immediate means as soon as possible no longer than 24 hours." The facility's policy revealed, as one of the key elements, "Patient/Resident representative is notified and documented timely." The policy does not specifically address "written" notifications being sent to Resident Representatives (RR) notifying them of a resident's transfer to an acute care hospital. Resident #10 A review of the medical record documentation for Resident #10, revealed a nursing department general progress note, dated 03/12/2019, which indicated Resident #10's Nurse Practitioner (NP) had given an order to transfer the resident to an acute care hospital for further evaluation of a painful and hardened red area to the right crease of the coccyx.	F 623	be construed as admission by the Center of any violation of state and federal statutes, regulations or standards of care. This plan of correction is to demonstrate compliance of the state and federal requirements cited during this survey. 1. The Responsible Party of Resident #10, #35, #65, #71, and #75 were notified in writing by the Center Social Worker on April 1, 2019 of past transfers and/or discharges for their resident. 2. Each Resident in the Center has the potential to be affected by this deficient practice. 3. An audit of Center resident discharges for the past 30 days was completed ensuring notification was made. This audit was completed on April 1, 2019 by the Center Business Office Manager and, if needed, the Social Worker made proper past notification on this date. In-service education was provided to nurses, nursing supervisors, department managers including Social Services, Business Office Manager, Director of Nursing Services, Activity Director, Medical Records, and Administrator. This education was provided by the Center Director of Education, a Registered Nurse/RN, and this education was provided during the dates of April 22, 2019 through May 3, 2019. This education expressed the requirement	

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F 623	Continued From page 4 During an interview, on 03/27/2019 at 8:50 AM, with Licensed Practical Nurse (LPN) #2/ Health Information Coordinator, she revealed that part of her job duties were the preparing and mailing out of the written notifications of transfer to the Resident Representatives (RR). LPN #2 stated, she had not been doing the written notifications, because she had only recently become aware that a letter needed to be sent out. LPN #2 stated, she had prepared and mailed the first one out last week. Resident #65 A review of the medical record documentation for Resident #65, revealed a nursing department general progress note, dated on 01/09/2019, which indicated Resident # 65's Nurse Practitioner (NP) had given an order to transfer the resident to an acute care hospital for further evaluation related to the resident's active oral bleeding. There was no documentation to indicate the RR had been notified of transfer. Resident #71 A review of the Discharge Return Anticipated Minimum Data Set (MDS) assessments with Assessment Reference Dates (ARD) of 11/24/2018, 01/19/2019 and 02/02/19, revealed, Resident #71's discharge status as being sent to an acute hospital. A record review for Resident #71, revealed the facility failed to notify the family in writing of the resident transfer to the hospital.	F 623	of each resident and responsible party leaving the Center, regardless of reason, to be provided a Notice of Transfer. The Center 's Medical Records Coordinator will audit each residents chart to ensure a Notice was provided. All charts will be audited weekly for the first two months, and bi-weekly for months three and four. This audit began April 1, 2019. 4. Monthly, results of these audits will be forwarded to the Center s Quality Assessment Performance Improvement Committee (QAPI). This Committee is comprised of the Medical Director, Administrator, Director of Nursing Services and three other department managers. This Committee will review the audits for additional monitoring and continued improvement and make recommendations as needed.	

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F 623	Continued From page 5 An interview on 03/27/2019 at 08:50 AM with LPN #2, confirmed, the facility failed to notify the family in writing of Resident #71's hospital transfer for all three (3) visits. The family was given a bed hold letter in writing. A review of the facility's Admission Record, revealed, the facility admitted Resident #71 on 12/04/2014, with diagnoses which included, End Stage Renal Disease, Cognitive Communication Deficit and Acquired Absence of Left Leg Above the Knee. Resident #79 Record review of the Resident #79's nurses notes, revealed, the resident was admitted to the facility on 1/4/2019 and sent to the hospital on 1/15/2019. There was no documentation to indicate that the RR was notified of transfer to hospital. An interview, on 03/27/2019 at 12:33 PM, with the Social Worker (SW), revealed, the resident had a short term stay. The SW revealed, Resident #79 went to the hospital, and was discharged either home or to another facility. A review of the Discharge Return Not Anticipated MDS Assessment for Resident #79, with an ARD of 01/18/19, revealed, the resident was discharged to an acute hospital. A review of the facility's Admission Record, revealed,Resident #79 was admitted by the facility on 01/04/2019, with diagnoses which included, Acute Kidney Failure, Hemiplegia and Hemiparesis Following Nontraumatic	F 623		

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F 623	Continued From page 6 Intracerebral Hemorrhage and Hypertension. A review of Resident #79's Admission MDS, with an ARD of 01/11/2019, the resident had a Brief Interview of Mental Status (BIMS) score of 15, which indicated cognitively intact. Resident #35 A record review of the physician orders for Resident #35, revealed an order dated 01/19/19, to send resident to (Name of Hospital) Emergency Room (ER) for Percutaneous Endoscopic Gastrostomy (PEG) tube replacement one (1) time only for 1 day. Review of the progress notes, dated 1/19/19 at 1:02 PM, revealed, Resident # 35 was admitted to (Name of Hospital) for PEG tube replacement. Record review of the MDS assessments for Resident #75, revealed, a Discharge Return Anticipated assessment with an ARD of 1/19/19, and a re-entry with an ARD of 1/21/19. On 3/27/19 at 8:50 AM, an interview with LPN #2, revealed, it was her responsibility to prepare and notify in writing of the resident's hospitalization. LPN #2 stated, she did not do it. LPN #2 revealed, she only recently became aware to notify the RR in writing, and sent her first one out last week.	F 623		
F 642 SS=D	Coordination/Certification of Assessment CFR(s): 483.20(h)-(j) §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate	F 642		5/4/19

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F 642	Continued From page 7 participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1)Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, facility policy review, and staff interview, the facility failed to complete a Discharge Minimum Data Set (MDS) assessment for one (1) of four (4) resident closed records reviewed; Resident #1. Findings include: A review of a statement provided by the facility, signed by the Interim Administrator, dated 03/28/2019, revealed, the facility uses the Long Term Care Facility Resident Assessment Instrument (RAI) User's Manual as the facility's	F 642	1. The Center Registered Nurse Assessment Coordinator (RNAC), a Registered Nurse/RN, completed a Death in the Facility Minimum Data Set (MDS) for Resident # 1 on March 28, 2019. 2. Each resident in the Center has the potential to be affected by this deficient practice. 3. An audit of all Center deaths within the Center occurring in the past six months was completed on April 15, 2019. This	

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F 642	Continued From page 8 policy and procedures for guidance for processing resident assessments. A review of Resident #1's Minimum Data Set (MDS) Assessment Summary report titled, "Evaluation History Report MDS 3.0," dated 03/27/2019, revealed Resident #1 had four MDS assessment that had been completed and transmitted. The assessments included an Entry, Admission, Significant Change , and Quarterly MDS. There was no record of a Discharge MDS assessment being completed or transmitted related to the resident's expiration. A review of the medical record documentation for Resident #1, revealed an admissions department general progress note, created on 11/21/2018, which indicated the resident was out on pass with the family. A review of the medical record documentation for Resident #1, revealed a nursing department general progress note, created on 11/24/2018, which indicated Resident #1's family returned to the facility on 11/24/2018 to report Resident #1 had passed away (expired) at 10:00 AM on 11/23/2018. During an interview, on 03/28/2019 at 9:46 AM, with Registered Nurse (RN) #1/ MDS Coordinator, she revealed the Discharge MDS assessment for Resident #1, who expired while out on pass with family, had not been completed. RN #1 stated, she realized yesterday, that the Discharge/Death in Facility MDS assessment had not been completed and submitted. RN #1 stated, that she would complete the MDS and submit it on today. RN #1 stated, "I just simply forgot, but I will get it done today."	F 642	audit was completed by the Center Business Office Manager (BOM) and both RNAC . For any omissions found the center RNAC will complete a Death in Center MDS. Each weekday the Center BOM will communicate to the Center RNACs any deaths occurring within the Center. For each death in the Center a Death in Center MDS will be completed by the RNAC within seven days of the event (death) and submitted to the Center s for Medicare and Medicaid Services (CMS) per State submission regulations. Education was provided to the Center RNACs on April 15, 2019 by the Regional Director of Clinical Reimbursement. This education included the process of checking the MDS scheduling software as a second way to check for Center deaths. The RNA C were also educated to use the CASPER Missing Assessment Report to verify the Center has no missing MDS assessments. 4. Monthly, results of these audits will be forwarded to the Center s Quality Assessment Performance Improvement Committee (QAPI). This Committee is comprised of the Medical Director, Administrator, Director of Nursing Services and three other department managers. This Committee will review the audits for additional monitoring and continued improvement and make recommendations as needed.	

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F 642	Continued From page 9 Review of the Admission Record, revealed, Resident #1 was admitted by the facility on 11/18/2011, and readmitted on 08/08/2018, with diagnoses to include Heart Failure and Chronic Obstructive Pulmonary Disease (COPD).	F 642		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and facility policy reviews, the facility failed to store and handle food in a sanitary manner to prevent possible cross-contamination for one (1) of three (3) kitchen tour observations. Findings include:	F 812	1. A thorough cleaning of the Center Kitchen was completed immediately, by the dietary team members, on March 28, 2019. This cleaning included removing all team member personal items from the food preparation area.	5/4/19

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F 812	Continued From page 10 A review of the facility's policy titled, "Dishwashing Procedures", with an effective date of 8/1/12, revealed: "Cleaned dishes must be allowed to air dry before storage. Warm water is an excellent medium for the growth of bacteria. Overhead racks and dish dollies are helpful, especially when space is limited." A review of the facility's policy titled, "Dry Storage", with an effective date of 8/1/12, revealed: it is the policy of this facility to store, prepare, and serve food that is stored in accordance with federal, state, and local sanitary codes. A review of the facility's statement, undated and signed by the Administrator, revealed: According to the Corporate Registered Dietician (RD), Diversicare of Meridian does not have an individual policy on storage of personal belongings by kitchen staff. An observation, on 3/26/19 at 11:45 AM, revealed, Dietary Staff (DS) #2 came into the kitchen area and placed her purse on the bottom rack of the kitchen preparation (prep) table where one (2) 18.1 kilograms (kg) box of white potatoes and one-half (1/2) of an 18.1 kg box of sweet potatoes were sitting. On 3/26/19 at 12:00 PM, an interview with DS#2, revealed, she sat her purse on a rack under the prep table with some white potatoes because she does not have anywhere to put her belongings, unless she leaves them in the car. DS #2 stated, "I know I'm not supposed to do that." An observation, on 3/26/19 at 12:14 PM, upon returning to the kitchen, revealed, two (2) other	F 812	2. Each resident in the Center receiving food from the kitchen has potential to be affected by this deficient practice. No residents were harmed by this deficient practice. 3. An educational in-service for all Dietary team members was completed between the dates of April 1, 2019 and May 3, 2019. This education was completed by the Center s Registered Dietician and included; proper stowing of personal items, food sanitation, general sanitation, cleaning schedules, not using wet dishes and proper dish room guidelines Daily, beginning April 1, 2019, the Center Dietary Manager or Dietary Supervisor in his absence, will make compliance rounds in the kitchen to ensure proper food preparation and sanitation of the kitchen. Also, twice weekly for two months and once weekly for two months the Center Administrator or designee will also make compliance rounds in the kitchen. 4. Monthly, results of these compliance rounds will be forwarded to the Center s Quality Assessment Performance Improvement Committee (QAPI). This Committee is comprised of the Medical Director, Administrator, Director of Nursing Services and three other department managers. This Committee will review the rounds for additional monitoring and continued improvement	

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F 812	Continued From page 11 personal bags on the bottom rack of the kitchen prep table with 1 18.1 KG box of white potatoes and1/2 box of an 18.1 KG box of sweet potatoes. On 3/26 19 at 12:17 PM, an interview with the Dietary Manager (DM), revealed, the staff personal belongings should not be on a rack, on the prep table, but should be in the office, because that is cross contamination. On 3/26/19 at 1:30 PM, an interview with DS #3, revealed, she has her medicine in her purse, so she puts it on a rack on the prep table. DS #3 stated, she guessed she could leave it in her car. She stated, it causes contamination by leaving her purse on a rack on the prep table. An observation, on 3/27/19 11:50 AM, revealed, wet nesting on 20 bottom plate domes, 1 bowl, and 1 plate. Also observed, was a piece of foil, from a wrapped baked potato, had fallen into the bacon bits. DS #1 retrieved the piece of foil, and continued to use the bacon bits. On 03/27/19 at 2:22 PM, an interview with the DM, revealed, wet nesting is when dishes are still damp in an area where they go. He stated, the facility had some wet nesting this morning on the tray line, and the dishes were rewashed and allowed to air dry. The DM stated, he is still learning his staff, and has only been at the facility for three (3) weeks. He stated, wet nesting allows germs to grow. The DM also stated, the dishwashing machine puts a sanitizer on the dishes to help prevent bacteria when they dry, so it did no good with the wet nesting. The DM stated, when the foil had fallen in the bacon bits, the foil contaminated the bacon bits, and DS #1 should have discarded the bacon bits and	F 812	and make recommendations as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255118	A. BUILDING _____ B. WING _____	03/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF MERIDIAN	4728 HIGHWAY 39 NORTH MERIDIAN, MS 39301

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F 812	Continued From page 12 recooked some more to use. The DM stated, it is cross contamination when the dietary staff bring their bags in from outside. On 3/27/19 4:10 PM, an interview with the Registered Dietician (RD) revealed, the staff personal items should not be under the prep table because it could be a form of contamination. She also stated, their personal items should be in their car. The RD stated, moisture is a problem with the dishes being wet. She stated, we call that wet stacking and it could cause bacteria. On 03/28/19 10:01 AM, an interview with DS #1, revealed, she stated the bottom domes were wet. She stated, the staff probably did not let them air dry when they came out of the dishwasher; the dishes should set for a while. DS #1 stated, with the dishes being wet, the water could be hot and someone could get scalded. She stated, wet dishes are called wetness. DS #2 also stated, the wet dishes probably could make the food soggy.	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255118	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/26/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF MERIDIAN	**4728 HIGHWAY 39 NORTH** **MERIDIAN, MS 39301**

(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
K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000		

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

Electronically Signed | 04/24/2019

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255118	A. BUILDING _____ B. WING _____	03/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF MERIDIAN	4728 HIGHWAY 39 NORTH MERIDIAN, MS 39301

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E 000	Initial Comments *EMERGENCY PREPAREDNESS* Survey conducted on 3/26/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were identified.	E 000		

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

Electronically Signed | 04/24/2019

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.