STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255108	A. BUILDING _____ B. WING _____	10/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREND HEALTH & REHAB OF CARTHAGE LLC	1101 EAST FRANKLIN STREET CARTHAGE, MS 39051

(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 The State Agency (SA) conducted an annual recertification along with a Complaint Investigation (CI), MS #16349, from 10/21/19 to 10/24/19. During the annual recertification survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation and cited F656, F658, F679, F693, and F759. The SA substantiated MS #16349 for an injury of unknown origin, with no citations related to the complaint. The facility is certified for 99 beds, with a census of 92 during the survey.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse	F 656		11/25/19

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

Electronically Signed | 11/21/2019

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 656	Continued From page 1 treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to follow the comprehensive care plan to provide desired activities for one (1) of 18 residents reviewed for care plans, Resident #50. Findings include: Review of the facility's "Following the Care Plan Policy", dated 1/2011, revealed all staff will follow a written and approved care plan to assure the resident's needs are met. Record review of Resident #50's comprehensive care plan, initiated 6/11/19, with a target date of 9/17/19, revealed interventions for activities,	F 656	On 10-22-19, the staff provided in room activity by turning the TV on for resident #50. Resident #50 has TV listed on her careplan as a like for stimulation. On 10-29-19, The activities care plan for resident #50 has been reviewed by the Activities Director and the Administrator and is now being followed. Resident #50 has been observed by the Administrator engaging in TV watching, listening to music and one on one visitation. All residents have the potential to be affected by this deficient practice.	

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F 656	Continued From page 2 which included offering and listening to the radio, watching Television (TV), and gospel Compact Discs (CDs) for audio stimulation. The care plan included an intervention to include the resident in enjoyable activities such as rhythm band, other musicals, special events, or spirituals as desired, as up, able, or willing. Record review of the activity logs revealed Resident #50 was provided four (4) activities for the month of August and three (3) activities for the month of September 2019. On 10/21/19 at 3:45 PM, an observation of Resident #50 revealed the resident in her bed, in her room, with her eyes open and no television (TV), radio, or compact disc (CD) playing. Resident #50 did not respond when spoken to. On 10/22/19 at 3:55 PM, an observation and interview of Resident #50, in her room, revealed she needed to be pulled up in bed. Resident #50 was unable to push the call light, due to she was unable to move her hands. Certified Nursing Assistants (CNAs) came into the room and repositioned Resident #50. No radio, CD, or TV was on at this time. Resident #50 did not respond when asked by the surveyor if she would like her radio on. On 10/22/19 at 4:13 PM, an interview with the Social Services Representative (SSR) revealed the Activity Director (AD) was not at the facility this week and she did not have an assistant. The SSR confirmed she felt like only three (3) or four (4) activities per month was not enough and she did not realize Resident #50 was not provided more activities. The SSR stated she talked to the AD and she did not have any other	F 656	On 10-29-2019 the Activities Director was in serviced by the Administrator on comprehensive care plan policy and procedure to provide desired activities according to resident preferences listed on care plan. Beginning on 11-18-2019, the Administrator will monitor five residents for in room activities and documentation weekly for four weeks to ensure that the activity care plan is being followed. Results will be brought to the Quality Assurance committee, by the Administrator, weekly for four weeks for recommendations and/or changes to ensure compliance.	

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F 656	Continued From page 3 documentation for activities other than the participation record for daily/weekly programs provided to the surveyor. On 10/24/19 at 4:28 PM, interview with the Director of Nursing (DON) confirmed Resident #50's care plan was not followed related to the activities. The DON revealed all nursing staff and department heads are responsible for developing and following care plans and the AD should have provided activities more often and as directed on the care plan. The DON revealed the AD was not in the facility and would not return the week the survey was in process.	F 656		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, standard of practice review, record review, and facility policy review, the facility failed to ensure appropriate procedures to prevent complications while administering medications via an inhaler medication. This was evidenced by the failure to have the residents rinse their mouth with water and spit, after inhalation, for two (2) of three (3) residents who were administered an inhaler, Resident #73 and Resident #2. Findings include:	F 658	Resident #73 and #2 were assessed by the Director of Nursing on 10-22-19 without any adverse reactions noted from not rinsing mouth and spitting after an oral inhalation medication administration. Resident #73 and #2 are now rinsing his/her mouth and spitting out the rinse water after receiving an oral inhalation medication. All residents with oral inhalation medication administration have had additional directions of "rinse mouth with water and spit out after administration of oral inhalation medication" added to the medication order and to the care plan.	11/25/19

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F 658	Continued From page 4 Review of "Mosby's Pocket Guide to Nursing Skills and Procedures", Perry and Potter, eighth edition, revealed to have the patient rinse mouth with warm water and expel the water about two (2) minutes after the last inhalation of medication. The rationale included to prevent dry mouth, taste alteration, and Corticosteroids can alter normal flora of the mucosa, causing development of fungal infections. Review of the facility's "Oral Inhalation Administration Procedures" policy, undated, revealed the policy is to allow for correct administration of oral inhalers to residents. Residents should rinse his/her mouth and spit out the rinse water after administration of an inhaler. Review of the documented insert from the Inhaler container, revealed instructions: after inhalation, the patient should rinse the mouth with water, without swallowing. Resident #73 On 10/22/19 at 8:04 AM, an observation revealed Licensed Practical Nurse (LPN) #1 administered a Symbicort (Corticosteroid) inhaler to Resident #73. The resident did not rinse and spit after inhalation of the medication. The LPN did not instruct the resident to rinse her mouth with water and spit. On 10/22/19 at 11:08 AM, interview with LPN #1 confirmed she did not instruct Resident #73 to rinse her mouth and spit after administering the Symbicort inhaler. LPN #1 revealed she honestly thought it was okay for the resident to drink some water after inhaling the Symbicort. LPN #1 stated she had passed medications for the Pharmacy Consultant and administered the Symbicort	F 658	Medical Doctor was notified with no new orders. Eighteen residents with oral inhalation medications were educated on rinsing his/her mouth and spitting out the rinse water after receiving an oral inhalation medication. All residents with oral inhalation medications are at risk for this deficient practice. On 10/22/2019, all licensed nursing staff were inserviced on oral inhalation administration procedures by the Director of Nursing. Starting on 11-18-2019, the Director of Nursing or the Assistant Director of Nursing will observe oral inhalation medication administration two times weekly for three months to ensure that residents who receive oral inhalation medications are rinsing with water and spitting out water after completion of the medication inhalation. The Director of Nursing or the Assistant Director of Nursing will bring all findings to the Quality Assurance committee weekly for recommendations and/or changes to ensure compliance for the next three months.	

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F 658	Continued From page 5 inhaler and the Consultant did not instruct her to have the resident rinse and spit. On 10/23/19 at 10:36 AM, the Director of Nursing (DON) stated she in-serviced the nursing staff in October 2019, on administration of inhalers and the policy to rinse and spit after inhalation. On 10/23/19 at 2:24 PM, an interview with the DON confirmed the policy for administering inhalers included rinsing the resident's mouth after administration and spitting out the water. On 10/24/19 at 1:30 PM, an interview with Resident #73 confirmed she has not rinsed or spit after inhalation until today. Resident #73 revealed no one ever told her about the procedure until today. RESIDENT #2 Observation of morning medication administration, on 10/22/19, by Licensed Practical Nurse #2, revealed the nurse did not instruct, nor did Resident #2 rinse her mouth with water, after inhalation of a Symbicort Inhaler. Interview with Licensed Practical Nurse #2, after the morning medication pass on 10/22/19, revealed "He refuses", when asked about the resident not rinsing his mouth after administration of the inhaler. Review of a nursing in-service, dated 10/10/19, revealed instructions on the use of inhalers, which included rinsing the mouth and expelling the water.	F 658		
F 679	Activities Meet Interest/Needs Each Resident	F 679		11/25/19

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F 679 SS=D	Continued From page 6 CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, record review, and facility policy review, the facility failed to provide an ongoing activity program consistent with the resident's interests, for one (1) of 18 residents reviewed for activities, Resident #50. Findings include: Review of the facility's "Activity Program" policy, dated 2008, revealed an ongoing program of activities is designed to meet the needs of each resident. Activities are scheduled daily. The activity program is designed to encourage restoration to self-care and maintenance of normal activity, which is geared to the individual resident's needs. The activity program consists of individual, and small and large group activities which are designed to meet the needs and interests of each resident. On 10/21/19 at 3:45 PM, an observation of Resident #50 revealed the resident in her bed, in her room, with her eyes open. The television (TV), radio, nor compact disc (CD) were playing.	F 679	On 10-22-19, the staff provided in room activity by turning the TV on for resident #50. Resident #50 has TV listed on her careplan as a like for stimulation. On 10-29-19, The activities care plan for resident #50 has been reviewed by the Activities Director and the Administrator and is now being followed. Resident #50 has been observed by the Administrator engaging in TV watching, listening to music and one on one visitation. All residents have the potential to be affected by this deficient practice. On 10-29-2019 the Activities Director was in serviced by the Administrator on comprehensive care plan policy and procedure to provide desired activities according to resident preferences listed on care plan. Beginning on 11-18-2019, the Administrator will monitor five	

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F 679	Continued From page 7 Resident did not respond to the surveyor when spoken to. During an interview and observation on 10/22/19 at 3:55 PM, Resident #50 stated she needed to be pulled up in bed. The resident was unable to push the call light, due to she's unable to move her hands. The Certified Nursing Assistants (CNAs) came into the room and repositioned Resident #50. There was no radio, CD, or TV on at this time and the resident did not respond when the surveyor asked if she would like her radio on. Review of the August and September 2019 activity logs revealed Resident #50 was provided four (4) activities for the month of August and three (3) activities in September. On 10/22/19 at 4:13 PM, during an interview, the Social Services Representative (SSR) revealed the Activity Director (AD) was not at the facility this week and she did not have an assistant. The SSR confirmed she felt only three (3) or four (4) activities per month was not enough and she did not realize Resident #50 was not provided more activities. The SSR revealed she talked to the Activity Director and there was no documentation for activities, other than the participation record for daily/weekly program, provided to the surveyor. On 10/24/19 at 4:28 PM, during an interview, the Director of Nursing (DON) confirmed the AD should provide Resident #50 activities more often and as directed on the care plan. The DON confirmed Resident #50's care plan revealed the resident liked activities such as rhythm band, other musicals, special events, or spirituals. The	F 679	residents for in room activities and documentation weekly for four weeks to ensure that the activity care plan is being followed. Results will be brought to the Quality Assurance committee, by the Administrator, weekly for four weeks for recommendations and/or changes to ensure compliance.	

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F 679	Continued From page 8 DON confirmed the resident should be offered the radio,TV, and gospel CD's for stimulation. The DON revealed the AD was not in the facility and would not return the week the survey was in process.	F 679		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure medications were administered via Percutaneous Endoscopic Gastrostomy (PEG) tube, per standard of practice, to prevent possible complications, as evidenced by four (4)	F 693	Resident #17 was assessed on 10-22-2019 by the Director of Nursing without adverse reactions noted. The order "may crush, combine and give all crushable medications together" was removed from resident #17's chart and all	11/25/19

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F 693	Continued From page 9 medications were crushed and administered together via PEG tube, for one (1) of six (6) residents observed for medication administration, Resident #17. Findings include: Facility policy review for "Medication Administration Via Tube Feeding", revised 2/2012, revealed: Give each drug separately to avoid incompatibility reactions with the tube ... Flush with five (5) milliliters (ml) of water between medications. Review of the "Mosby's Pocket Guide to Nursing Skills and Procedures", Perry and Potter, eighth edition, revealed: To administer more than one (1) medication via feeding tube, crush each tablet into a fine powder and dissolve each tablet in a separate cup of 30 ml of warm water. Give each medication separately and flush between medications with 15 to 30 ml of water. This maintains patency and allows for accurate identification of medication if a dose is spilled. In addition, some medications may be incompatible. Observation of the medication (med) administration pass, by Licensed Practical Nurse #2, on 10/22/19 at 9:07 AM, revealed the following medications were crushed, mixed together, and administered together via Resident #17's feeding tube: Seroquel 25 milligram (mg), Certrizine 10 mg, Calcium 600 mg, Vitamin D 400 international units (IU), and Tramadol 50 mg. Record review of Resident #17's current Physician Orders and Medication Administration Record, revealed an order dated 7/29/2019, which included orders to flush the Percutaneous	F 693	other residents charts with Percutaneous Endoscopic Gastrostomy tubes. Resident #17 was assessed on 10-22-2019 by the Director of Nursing without adverse reactions noted. Medical Doctor was notified with no new orders. All five residents with Percutaneous Endoscopic Gastrostomy tubes have the potential to be affected by this deficient practice. Resident #17's medications are now being crushed separately and given separately with thirty cubic centimeters of water before administration via Percutaneous Endoscopic Gastrostomy tube and five cubic centimeters of water flushes between each medication and thirty cubic centimeters of water flush after all meds. On 10/22/2019 all licensed nurses were inserviced on administering medications via a Percutaneous Endoscopic Gastrostomy tube by the Director of Nursing. Starting on 11-18-2019, the Registered Nurse Supervisor or the Infection Preventionist Nurse will observe preparation and administration of medications via Percutaneous Endoscopic Gastrostomy tube two times weekly for three months to ensure that residents who receive medications via a Percutaneous Endoscopic Gastrostomy tube are being crushed separately and administered separately with five cubic centimeters of water flush between each medication. Results of observations will be brought to	

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F 693	Continued From page 10 Endoscopic Gastrostomy (PEG) tube every shift with 30 cubic centimeters (cc) of water, before and after medications, and five (5) ml between meds, if administered via PEG tube. An order dated 12/5/2018, revealed: May crush, combine, and give all crushable meds together. There was no order for fluid restriction, nor was there a statement that all medications were compatible when crushed and combined for PEG tube administration. Interview with Licensed Practical Nurse #2 on 10/22/19 at 9:07 AM, revealed, "All our residents have that order", referring to the order to crush, combine and give all crushable meds together. She also stated that the resident didn't have an order for fluid restriction.	F 693	the Quality Assurance committee by the Registered Nurse Supervisor or the Infection Prevention Nurse weekly for three months for recommendations and/or changes to ensure compliance for the next three months.	
F 759 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, staff interview, and facility policy review, the facility failed to ensure the medication error rate was less than five (5) percent (%), as evidenced by four (4) medications were crushed and administered together via an enteral tube. This was four (4) of 56 opportunities observed during medication pass, which affected Resident #17. Findings include:	F 759	Resident #17 was assessed on 10-22-2019 by the Director of Nursing without adverse reactions noted. The order "may crush, combine and give all crushable medications together" was removed from resident #17's chart and all other residents charts with Percutaneous Endoscopic Gastrostomy tubes. Resident #17 was assessed on 10-22-2019 by the Director of Nursing without adverse reactions noted. Medical Doctor was	11/25/19

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F 759	Continued From page 11 Facility policy review for "Medication Administration Via Tube Feeding", revised 2/2012, revealed: Give each drug separately to avoid incompatibility reactions with the tube ... Flush with five (5) milliliters (ml) of water between medications. Review of the "Mosby's Pocket Guide to Nursing Skills and Procedures", Perry and Potter, eighth edition, revealed: To administer more than one (1) medication via feeding tube, give each medication separately and flush between medications with 15 to 30 ml of water. This maintains patency and allows for accurate identification of medication if a dose is spilled. In addition, some medications may be incompatible. Observation of medication administration, by Licensed Practical Nurse #2, on 10/22/19 at 9:07 AM, revealed the following medications were crushed, mixed together, and administered together via Resident #17's feeding tube: Seroquel 25 milligram (mg), Certrizine 10 mg, Calcium 600 mg, Vitamin D 400 international units (IU), and Tramadol 50 mg. Review of Resident #17's current Physician Orders and Medication Administration Record (MAR), revealed orders dated 7/29/2019, to flush the Percutaneous Endoscopic Gastrostomy (PEG) tube every shift with 30 cubic centimeters (cc) of water, before and after medications, and five (5) ml between meds, if administered via PEG tube. An order dated 12/5/2018, revealed: May crush, combine, and give all crushable meds together. Resident #17 did not have an order for fluid restriction, nor was there a statement that all medications were compatible when crushed and combined for PEG tube administration.	F 759	notified with no new orders. All five residents with Percutaneous Endoscopic Gastrostomy tubes have the potential to be affected by this deficient practice. Resident #17's medications are now being crushed separately and given separately with thirty cubic centimeters of water before administration via Percutaneous Endoscopic Gastrostomy tube and five cubic centimeters of water flushes between each medication and thirty cubic centimeters of water flush after all meds. On 10/22/2019 all licensed nurses were inserviced on administering medications via a Percutaneous Endoscopic Gastrostomy tube by the Director of Nursing. Starting on 11-18-2019, the Registered Nurse Supervisor or the Infection Preventionist Nurse will observe preparation and administration of medications via Percutaneous Endoscopic Gastrostomy tube two times weekly for three months to ensure that residents who receive medications via a Percutaneous Endoscopic Gastrostomy tube are being crushed separately and administered separately with five cubic centimeters of water flush between each medication. Results of observations will be brought to the Quality Assurance committee by the Registered Nurse Supervisor or the Infection Prevention Nurse weekly for three months for recommendations and/or changes to ensure compliance for the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255108	A. BUILDING _____ B. WING _____	10/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 759	Continued From page 12 Interview with Licensed Practical Nurse #2 on 10/22/19 at 9:07 AM, revealed, "All our residents have that order", referring to the order to crush, combine and give all crushable meds together. She also stated that Resident #17 didn't have an order for fluid restriction.	F 759	next three months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255108	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/22/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREND HEALTH & REHAB OF CARTHAGE LLC	**1101 EAST FRANKLIN STREET** **CARTHAGE, MS 39051**

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K 000	INITIAL COMMENTS 42 483.70(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

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
	255108	A. BUILDING _____ B. WING _____	10/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E 000	Initial Comments ********** Survey conducted on 10/22/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were cited.	E 000		

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.