

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/13/2026
NAME OF PROVIDER OR SUPPLIER BLOOM AT GERMAN CHURCH		STREET ADDRESS, CITY, STATE, ZIP CODE 2250 HARVEST MOON DR, INDIANAPOLIS, , 46229			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE	
R 0000	INITIAL COMMENTS This visit was for the Investigation of Intake IN00471340. Intake IN004713400 - State deficiencies related to the allegations are cited at R29, R241, R378, and R383. Survey dates: August 12 and 13, 2026 Facility number: 003916 Residential Census: 52 These State Residential Findings are cited in accordance with 410 IAC (Indiana Administrative Code) 16.2-5. Quality review completed August 19, 2026.	R 0000			
R 0029	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(d) (d) Residents have the right to be	R 0029	R 029 What corrective action(s) will be accomplished for those	09/15/2026	

treated with consideration, respect, and recognition of their dignity and individuality.

Based on interview and record review, the facility failed to ensure residents were treated with consideration and respect in regard to the behavior of another resident for 6 of 52 residents in the facility.
(Residents H, J, K, L, M and G)

Findings include:

An interview was conducted with the Executive Director (ED) on 8/12/26 at 10:17 a.m. She indicated they were seeking alternate placement for Resident B. There was "a lot going on with him." He began having aggressive behaviors at the end of July, 2026. He became upset in the dining room, was being loud, and hit the wall during the lunch meal service. He punched his fist into his palm and indicated his fists could kill, but did not direct it at anyone specific. There were about 30 other residents in the dining room at the time. Residents informed her they did not like it; it was scary and noisy and did not want Resident B in the facility. Resident B was sent to a local hospital for evaluation and treatment after that incident. Over the next few days, Residents H, J, K, and L all came to her with concerns

residents found to have been affected by the deficient practice:

Residents H, J, K, L, M, and G will be met with individually by the Executive Director/designee to address their concerns, provide reassurance, and ensure they feel safe and respected. Service plans for affected residents will be reviewed to ensure appropriate supportive measures are in place. Resident B will be evaluated to ensure appropriate interventions are in place based on his assessed needs and current condition. Resident B's medication orders will be reviewed and reconciled to ensure prescribed medications are available and administered as ordered.

How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:

All residents residing in the community have the potential to be affected. The Executive Director/designee will complete a facility-wide audit of resident behavioral concerns, incident reports, and grievances to identify any additional resident rights or dignity concerns requiring follow-up. Any

about Resident B's behavior. Resident B came back to the facility on 7/31/26 and had extra supervision upon return. He was okay for a couple of day, but would get loud. On 8/4/26 he was observed by staff to make sexually inappropriate gestures towards them. The ED filed a police report a few days ago after Resident D stood at the end of the hall, just staring and wouldn't respond. The police informed her they could get some sort of document signed by a judge, so that the next time he was sent to the hospital, he would be unable to return. The facility decided not to move forward with that and to discuss the situation with Resident B's Powers of Attorney to find alternate placement. Resident B seemed to switch to being upset quickly. He knocked on Resident K's door asking her to come eat breakfast and she didn't like it. The ED was concerned Resident B could become angry and aggressive at any point. He was currently on 15 minute checks and all staff were alerted to call the police if they saw anything out of the way. There were signs to do so in the break room and nurse's station. The ED had never heard him cuss at other residents, but she'd heard him be loud and other residents informed her he cussed.

concerns identified will be investigated and addressed as appropriate.

What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:

All associates will be re-educated regarding Resident Rights, Dignity, Behavior Management, and De-escalation Protocols. Associates will be re-educated on the requirement to promptly report and document resident-to-resident behavioral concerns and resident dignity concerns so concerns can be appropriately investigated and addressed. Emergency response procedures, including appropriate notification of facility leadership and law enforcement when warranted by the circumstances, will also be reviewed and reinforced.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:

The Executive Director will conduct weekly audits of behavioral documentation, resident incident reports, and grievance documentation for four (4) weeks, then monthly for

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

An interview was conducted with Resident M on 8/13/26 at 2:37 p.m. She indicated there was an issue with Resident B. He could be mean. He'd yelled and cussed at her three or four times. He stood outside her door praying, waving his hand. Resident M tried to stay away from Resident B and would tell staff, who would escort Resident B away. "I just feel uncomfortable around him." If Resident M informed the nurse, they would handle the issue right away, but not necessarily the aides.

An interview was conducted with Resident G on 8/12/26 at 3:05 p.m. Resident G indicated Resident B got mad and yelled at a nurse in front of her one day. It made Resident G feel uncomfortable.

An investigative file into Resident B's behaviors was provided by the ED on 8/13/26 at 10:15 a.m. It included a statement from an activity staff member, dated 8/6/26. The statement indicated during an activity, Resident B was observed touching female residents on the shoulder and holding one resident's hand. The contact did not appear to be inappropriate, in nature, however, the residents verbally expressed that they did not want to be touched and told him

five (5) months to verify that behavioral and dignity concerns are appropriately documented, investigated, and addressed. Findings will be reviewed through the facility's Quality Assurance process monthly. Identified concerns will be addressed through additional education, corrective action, or process improvement as indicated by the audit findings.

By what date the systemic changes will be completed:

09/15/2026

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

	to not touch them. The Bill of Rights policy was provided by the ED on 8/13/26 at 3:29 p.m. It indicated, "In accordance with this right to dignity and respect, residents are entitled to all of the freedom and privileges of any there citizen...Every Resident Shall Have The Right to: ...Courteous treatment in address and handling." This Citation relates to Intake IN00471340.			
R 0241	Health Services - Offense 410 IAC 16.2-5-4(e)(1) (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on interview and record review, the facility failed to administer a resident's antipsychotic medication, as ordered, for 1 of 3 residents reviewed for behaviors. (Resident B)	R 0241	R 241 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident B's clinical record, current medication orders, and Medication Administration Record (MAR) will be reviewed and reconciled to verify that all currently ordered medications are available and administered as prescribed. Any discrepancies identified will be promptly addressed with the appropriate prescribing provider and pharmacy. How the facility will identify other residents having the potential to be affected by the	09/15/2026

Findings include:

The clinical record for Resident B was reviewed on 8/12/26 at 11:14 a.m. Resident B's diagnoses included, but were not limited to, schizoaffective disorder. Resident B was admitted to the facility on 6/26/26 from home.

The After Visit Summary from Resident B's mental health care provider, dated 7/15/26, indicated Resident B's current medications included Olanzapine (commonly known by the brand name Zyprexa-atypical antipsychotic prescription medication used to treat schizophrenia and bipolar I disorder) 30 mg at bedtime.

The June, 2026, July, 2026, and August, 2026 MARs (medication administration records) at the facility indicated Resident B did not begin receiving Olanzapine at the facility until 8/2/26.

The progress note, dated 7/28/26, indicated the Executive Director (ED) and Activity Director (AD) took Resident B to a local hospital, because he was hitting and pushing the wall, and stating he would "hurt/kill" someone and be in jail like his brother.

The hospital note, dated 7/29/26, indicated, "Primary diagnosis for assessment likely

same deficient practice and what corrective action will be taken:

All residents receiving medication administration or supervision have the potential to be affected. The Executive Director will ensure a 100% audit of current resident MARs is completed against current physician orders and available hospital discharge documentation to verify that ordered medications are available and administered as prescribed. Any discrepancies identified through the audit will be promptly investigated and corrected.

What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:

Licensed nursing associates and Qualified Medication Aides (QMAs) will be re-educated regarding Medication Administration Policies, verification of medication orders upon admission and return from hospitalization, and procedures for addressing unavailable or missing medications. The admission and transition-of-care medication reconciliation process will be reinforced to ensure incoming medication orders are reviewed and verified

schizoaffective disorder depressive type per documentation review from prior psychiatry provider at [name of Resident B's mental health care provider referenced in the above order for Olanzapine...] Suspect that pt's [patient's] aggression in ALF [assisted living facility] could be due to pt not receiving prescribed Zyprexa...Will start 15 mg Zyprexa, currently not receiving at ALF but prescribed by [name of physician] on 6/22 [6/22/26,] will provide at discharge and recommend outpatient follow up to optimize medication management." The discharge orders, dated 7/31/26, from the hospital indicated to administer one 15 mg tablet of Olanzapine nightly.

The July, 2026 and August, 2026 MARs indicated Resident B did not receive the ordered Olanzapine on 7/31/26 or 8/1/26 due to "medication not available."

An interview was conducted with Licensed Practical Nurse (LPN) 2 on 8/13/26 at 2:11 p.m. LPN 2 indicated they did not feel comfortable around Resident B, because he would yell at you for no reason. If he wanted something done, he would not wait, and you had to do it right then. LPN 2 noticed the Zyprexa order on the after visit summary from 7/15/26 and

by appropriate licensed nursing personnel prior to medication administration.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:

The Executive Director will ensure 100% of new admission and hospital return medication records are audited weekly for four (4) weeks to verify medication reconciliation was completed and ordered medications are available and administered as prescribed. Thereafter, the Executive Director will ensure a sample of 20% of resident MARs is audited monthly for five (5) months. Findings will be reviewed through the facility's Quality Assurance process. Identified concerns will be addressed through additional education, corrective action, or process improvement as indicated by the audit findings.

By what date the systemic changes will be completed:

09/15/2026

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

FORM APPROVED

OMB NO. 0938-0391

that they were not administering it to him. LPN 2 figured that was the reason for the start of his behaviors.

An interview was conducted with the ED on 8/13/26 at 11:29 a.m. The ED indicated they did not have the Olanzapine order upon Resident B's 6/26/26 admission, so he did not begin receiving it until after he came back from the the July, 2026 hospitalization.

On 8/13/26 at 12:34 p.m., an interview was conducted with Resident B's Care Coordinator from Resident B's mental health care provider that prescribed the Olanzapine on 6/22/26. The Care Coordinator indicated they normally coordinated mental health care for patients when they resided in an assisted living facility. They had no contact with this particular facility in regards to Resident B's treatment.

The Medications policy was provided by the ED on 8/13/26 at 11:30 a.m. It indicated, "It is the policy of [name of facility] to supervise or administer all medications that the residents receive as ordered by their physician. [Name of facility] provides appropriate method and procedures for the obtaining, dispensing and administering of drugs approved

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

	by the Wellness Director and consulting Pharmacist." This Citation relates to Intake IN00471340.			
R 0378	Mental Health Screening-Deficiency 410 IAC 16.2-5-11.1(b)(1)(A-H)(2-3) (b) If the individual is a recipient of Medicaid or federal Supplemental Security Income (SSI), the individual needs evaluation provided in section 2(a) of this rule shall include, but not be limited to, the following: (1) Screening of the individual for major mental illness, such as a diagnosed major mental illness, is limited to the following disorders: (A) Schizophrenia. (B) Schizoaffective disorder. (C) Mood (bipolar and major depressive type) disorder. (D) Paranoid or delusional disorder. (E) Panic or other severe anxiety disorder. (F) Somatoform or paranoid disorder. (G) Personality disorder. (H) Atypical psychosis or other psychotic disorder (not otherwise	R 0378	R 378 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident B's clinical record will be reviewed and updated to include the required documentation of his mental health treatment history for the previous two (2) years and behavioral history for the previous two (2) years. The Executive Director/designee will obtain the necessary documentation from Resident B's outpatient mental health provider, care coordinator, and/or prior providers and maintain the documentation in his clinical record. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All current residents who are recipients of Medicaid or federal Supplemental Security Income	09/15/2026

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

	specified). (2) Obtaining a history of treatment received by the individual for a major mental illness within the last two (2) years. (3) Obtaining a history of individual behavior within the last two (2) years that would be considered dangerous to facility residents, the staff, or the individual. Based on interview and record review, the facility failed to obtain a two year treatment history for a major mental illness for 1 of 3 residents reviewed for behaviors. (Resident B) Findings include: The clinical record for Resident B was reviewed on 8/12/26 at 11:14 a.m. Resident B's diagnoses included, but were not limited to, schizoaffective disorder. Resident B was admitted to the facility on 6/26/26 from home. The After Visit Summary from Resident B's mental health care provider, dated 7/15/26, indicated Resident B's current medications included Olanzapine (commonly known by the brand name Zyprexa- atypical antipsychotic prescription medication used to treat schizophrenia and bipolar I disorder) 30 mg at bedtime.		(SSI) have the potential to be affected. The Executive Director/designee will complete a 100% audit of applicable current resident clinical records to verify that the required individual needs evaluation includes screening for major mental illness and the required treatment and behavioral histories. Any missing documentation identified during the audit will be obtained and added to the applicable resident's clinical record. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:	
--	---	--	---	--

The June, 2026, July, 2026, and August, 2026 MARs (medication administration records) at the facility indicated Resident B did not begin receiving Olanzapine at the facility until 8/2/26.

The progress note, dated 7/28/26, indicated the Executive Director (ED) and Activity Director (AD) took Resident B to a local hospital, because he was hitting and pushing the wall, and stating he would "hurt/kill" someone and be in jail like his brother.

The hospital note, dated 7/29/26, indicated, "Primary diagnosis for assessment likely schizoaffective disorder depressive type per documentation review from prior psychiatry provider at [name of Resident B's mental health care provider referenced in the above order for Olanzapine...] Suspect that pt's [patient's] aggression in ALF [assisted living facility] could be due to pt not receiving prescribed Zyprexa...Will start 15 mg Zyprexa, currently not receiving at ALF but prescribed by [name of physician] on 6/22 [6/22/26,] will provide at discharge and recommend outpatient follow up to optimize medication management."

An interview was conducted with Licensed Practical Nurse (LPN) 2 on 8/13/26 at 2:11 p.m.

Admission pre-screening procedures will be reinforced to ensure applicable residents receive the required mental health screening as part of the individual needs evaluation prior to admission. The screening process will include obtaining the required two-year treatment history for major mental illness and two-year history of behavior considered dangerous to the resident, other residents, or staff. The Executive Director and associates involved in the admission process will be re-educated regarding the applicable requirements of Indiana Residential Care Rule 410 IAC 16.2-5-11.1(b).

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:

The Executive Director will audit 100% of applicable new admission records prior to admission to verify completion of the required mental health screening and supporting documentation. Results of the admission audits will be tracked monthly for six (6) months and reviewed through the facility's Quality Assurance process. Identified concerns will be addressed through additional education, corrective action, or

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

LPN 2 indicated they did not feel comfortable around Resident B, because he would yell at you for no reason. If he wanted something done, he would not wait, and you had to do it right then. LPN 2 noticed the Zyprexa order on the after visit summary from 7/15/26 and that they were not administering it to him. LPN 2 figured that was the reason for the start of his behaviors.

An interview was conducted with the ED on 8/13/26 at 11:29 a.m. The ED indicated they did not have the Olanzapine order upon Resident B's admission, so he did not begin receiving it until after he came back from the July, 2026 hospitalization.

On 8/13/26 at 12:34 p.m., an interview was conducted with Resident B's Care Coordinator from Resident B's mental health care provider that prescribed the Olanzapine on 6/22/26. The Care Coordinator indicated they normally coordinated mental health care for patients when they resided in an assisted living facility. They had no contact with this particular facility in regards to Resident B's treatment.

The Bill of Rights policy was provided by the ED on 8/13/26 at 3:29 p.m. It indicated, "Every Resident Shall Have The Right

process improvement as indicated by the audit findings.

By what date the systemic changes will be completed:

09/15/2026

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

	to: A. Receive adequate and appropriate care and treatment." This Citation relates to Intake IN00471340.			
R 0383	Mental Health Screening - Deficiency 410 IAC 16.2-5-11.1(g)(1-2) (g) The residential care facility, in cooperation with the mental health service providers, shall develop the comprehensive careplan for the resident that includes the following: (1) Psychosocial rehabilitation services that are to be provided within the community. (2) A comprehensive range of activities to meet multiple levels of need, including the following: (A) Recreational and socialization activities. (B) Social skills. (C) Training, occupational, and work programs. (D) Opportunities for progression into less restrictive and more independent living arrangements. Based on interview and record review, the facility failed to develop a comprehensive care plan in cooperation with a resident's mental health care provider for 1 of 3 residents reviewed for behaviors.	R 0383	9/15/2026 R 383 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident B's comprehensive care plan will be reviewed and updated in cooperation with the applicable mental health service provider. The comprehensive care plan will reflect Resident B's identified mental health and psychosocial needs and will include applicable interventions and services based on recommendations received from the mental health service provider. Documentation demonstrating collaboration with the mental health service provider will be maintained in Resident B's clinical record. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:	09/15/2026

(Resident B)

Findings include:

The clinical record for Resident B was reviewed on 8/12/26 at 11:14 a.m. Resident B's diagnoses included, but were not limited to, schizoaffective disorder. Resident B was admitted to the facility on 6/26/26 from home.

The After Visit Summaries from Resident B's mental health care provider, dated 6/16/26 and 7/15/26, indicated Resident B's current medications included Olanzapine (commonly known by the brand name Zyprexa- atypical antipsychotic prescription medication used to treat schizophrenia and bipolar I disorder), Escitalopram (commonly known by the brand name Lexapro- a prescription antidepressant used to treat major depressive disorder and generalized anxiety disorder), and Invega Sustenna (long-acting atypical antipsychotic injection given once a month by a healthcare professional, approved to treat schizophrenia and schizoaffective disorder in adults.)

The Special Care Needs section of Resident B's service plan, dated 6/29/26, indicated he received mental health services from the above mental health

All residents with a major mental illness who require a comprehensive care plan developed in cooperation with a mental health service provider have the potential to be affected. The Executive Director/designee will audit applicable current resident clinical records to verify that comprehensive care plans have been developed in cooperation with the applicable mental health service provider. The audit will verify that documentation supporting provider collaboration is maintained within the resident's clinical record. Any deficiencies identified will be corrected.

What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:

A process will be implemented to ensure timely communication and coordination with the applicable mental health service provider for residents with major mental illness requiring a comprehensive care plan. Communication and recommendations received from the mental health service provider will be documented within the resident's clinical record and incorporated into the resident's comprehensive care plan as applicable. Associates

care provider. The objective/plan was for the facility's care team to monitor for changes in condition and conduct a reappraisal as appropriate. The Coordination with Outside Agencies section of the service plan indicated the objective/plan was for the facility's care team to monitor for changes in condition and conduct a reappraisal as appropriate. Provide information about rights to make decisions regarding care and services. Coordinate telemedicine visits and follow up. Coordinate health care lab work. Coordinate health care related x-rays or other testing. The service plan was signed by the Director of Nursing (DON,) Executive Director (ED,) and Resident B's representative. There was no signature or other indication the plan was developed in cooperation with Resident B's mental health care provider.

The June, 2026, July, 2026, and August, 2026 MARs (medication administration records) at the facility indicated Resident B did not begin receiving Olanzapine at the facility until 8/2/26.

The progress note, dated 7/28/26, indicated the ED and Activity Director (AD) took Resident B to a local hospital, because he was hitting and pushing the wall, and stating he

involved in resident assessment, service planning, and clinical documentation will be re-educated regarding the requirement to develop applicable comprehensive care plans in cooperation with the mental health service provider and to maintain documentation demonstrating that collaboration.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:

The Executive Director will audit 100% of applicable comprehensive care plans weekly for four (4) weeks, then monthly for five (5) months to verify that the comprehensive care plan addresses the resident's identified mental health and psychosocial needs and that documentation demonstrating cooperation with the applicable mental health service provider is maintained in the resident's clinical record. Findings will be reviewed through the facility's Quality Assurance process. Identified concerns will be addressed through additional education, corrective action, or process improvement as indicated by the audit findings.

By what date the systemic

would "hurt/kill" someone and be in jail like his brother.

The hospital note, dated 7/29/26, indicated, "Primary diagnosis for assessment likely schizoaffective disorder depressive type per documentation review from prior psychiatry provider at [name of Resident B's mental health care provider referenced in the above order for Olanzapine...] Suspect that pt's [patient's] aggression in ALF [assisted living facility] could be due to pt not receiving prescribed Zyprexa...Will start 15 mg Zyprexa, currently not receiving at ALF but prescribed by [name of physician] on 6/22 [6/22/26,] will provide at discharge and recommend outpatient follow up to optimize medication management."

An interview was conducted with Licensed Practical Nurse (LPN) 2 on 8/13/26 at 2:11 p.m. LPN 2 indicated they did not feel comfortable around Resident B, because he would yell at you for no reason. If he wanted something done, he would not wait, and you had to do it right then. LPN 2 noticed the Zyprexa order on the after visit summary from 7/15/26 and that they were not administering it to him. LPN 2 figured that was the reason for the start of his behaviors.

changes will be completed:

09/15/2026

An interview was conducted with the ED on 8/13/26 at 11:29 a.m. The ED indicated they did not have the Olanzapine order upon Resident B's admission, so he did not begin receiving it until after he came back from the July, 2026 hospitalization. She thought they developed his service plan in coordination with the mental health care provider who came to the facility, but not Resident B's mental health care provider.

On 8/13/26 at 12:34 p.m., an interview was conducted with Resident B's Care Coordinator from his mental health care provider that prescribed the Olanzapine on 6/22/26. The Care Coordinator indicated they normally coordinated mental health care for patients when they resided in an assisted living facility. They had no contact with this particular facility in regards to Resident B's treatment.

The Client Service Plan policy was provided by the ED on 8/13/26 at 10:15 a.m. It indicated, "The Client Service Plan should be completed and reviewed by the community care team and the client/legally responsible party within 14-30 days (per State regulations) after admission of the client or as required by State regulations."

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

FORM APPROVED

OMB NO. 0938-0391

	This Citation relates to Intake IN00471340.			
--	--	--	--	--

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATUREKim Lingle	TITLEExecutive Director	(X6) DATE08/31/2026
---	-------------------------	---------------------