STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VICTORIAN OF GREENWOOD	2339 S STATE ROAD 135, GREENWOOD, , 46143

(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 a State Residential Licensure Survey. Survey dates: April 15 and 16, 2025 Facility number: 005722 Residential Census: 91 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed April 21, 2025.	R 0000		
R 0092	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(i)(1-2) (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire	R 0092	**Facility ID 005722** **R92-Administration and Management Nonompliance-(Fire Drills)** **What corrective action(s) will be**	06/05/2025

	alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on interview and record review, the facility failed to ensure that 9 of the 12 total required annual fire drills were conducted for the calendar year for 2024. Finding includes: On 4/16/25 at 11:30 a.m., the ED (Executive Director) provided documentation of fire drills conducted for the calendar year for 2024. A review of the records indicated that there were three fire drills conducted on 12/27/24, one drill each on 1st, 2nd, and 3rd shifts.		**accomplished for those residents found to have been affected by the alleged deficient practice:** **No residents were adversely affected by the deficient practice** **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:N/A** **All Fire Dille Up to date 5.6.25** **Fire Drill Schedule – Fire Drills Monthly** **QA Maintenance Manager or designee monthly to assure Fire Drill procedures are completed x 12 months** **Fire Department Invited to observe a fire drill on site May 2025**	

	During an interview on 4/16/25 at 11:30 a.m., the ED indicated during the calendar year 2024, the facility conducted three fire drills during the month of December. The facility was to conduct at least 12 fire drills per year. On 4/16/25 at 11:55 a.m., the ED indicated that the facility lacked a policy specific to the number of fire drills and the facility followed state regulations and guidelines. Based on interview and record review, the facility failed to ensure that 9 of the 12 total required annual fire drills were conducted for the calendar year for 2024. Finding includes: On 4/16/25 at 11:30 a.m., the ED (Executive Director) provided documentation of fire drills conducted for the calendar year for 2024. A review of the records indicated that there were three fire drills conducted on 12/27/24, one drill each on 1st, 2nd, and 3rd shifts. During an interview on 4/16/25 at 11:30 a.m., the ED indicated during the calendar year 2024, the facility conducted three fire drills during the month of December. The facility was to conduct at least 12 fire drills per year.			

	On 4/16/25 at 11:55 a.m., the ED indicated that the facility lacked a policy specific to the number of fire drills and the facility followed state regulations and guidelines.			
R 0116	Personnel - Noncompliance 410 IAC 16.2-5-1.4(a) (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. Based on interview and record review, the facility failed to maintain accurate personnel records and documentation of references having been conducted for 2 of 3 newly hired employees reviewed for employee records. (QMA 7, Dietary Aide 5) Finding includes: On 4/16/25 at 10:00 a.m., the Executive Director provided a list of current employees with date of hire and associated position titles. 1. On 4/16/25 at 10:15 a.m., Qualified Medication Aide (QMA) 7's personnel file was	R 0116	Facility ID: 005722 R116-Personnel-Noncompliance 1 What Corrective action(s) will be accomplished for the staff found to have been affected by the alleged deficient practice a 2 How the facility will identify other staff having the potential to be affected by the same deficient practice and what corrective will be taken An audit of all employee files will be completed by the Business Office Manager. The employee files found to be out of compliance during the audit will have Reference checks completed on or before 6/5/2025	06/05/2025

	reviewed. QMA 7 was hire on 4/7/25 and was currently employed at the facility. The personnel file lacked documentation that QMA 7's applicable employee references had been conducted. 2. On 4/16/25 at 10:20 a.m., Dietary Aide 5's personnel file was reviewed. Dietary Aide 5 was hired on 2/7/25 and was currently employed at the facility. The personnel file lacked documentation that Dietary Aide 5's applicable employee references had been conducted. During an interview on 4/16/25 at 11:20 a.m., the Executive Director indicated that the facility was unable to locate any documented references for QMA 7 and Dietary Aide 5. The employee files should have contained documentation that showed the employee references had been completed. On 4/16/25 at 12:20 p.m., the Executive Director provided a copy of the Personnel Records policy, dated January 2023, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...Personnel records on all employees will be kept in a central location in the community...the following documents will be retained in		3 What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: a .The Business Office Manager will conduct an audit of employee files weekly for 4 weeks and monthly for 3 months. Variances will be corrected at the time of observation 4 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: a BOM and/ or ED to Results to be reviewed at monthly QI meetings and make further recommendations based off audit results. 5 By what date will the systematic changes be completed _ 6/5/2025	

	the personnel file...reference inquiry..." Based on interview and record review, the facility failed to maintain accurate personnel records and documentation of references having been conducted for 2 of 3 newly hired employees reviewed for employee records. (QMA 7, Dietary Aide 5) Finding includes: On 4/16/25 at 10:00 a.m., the Executive Director provided a list of current employees with date of hire and associated position titles. 1. On 4/16/25 at 10:15 a.m., Qualified Medication Aide (QMA) 7's personnel file was reviewed. QMA 7 was hire on 4/7/25 and was currently employed at the facility. The personnel file lacked documentation that QMA 7's applicable employee references had been conducted. 2. On 4/16/25 at 10:20 a.m., Dietary Aide 5's personnel file was reviewed. Dietary Aide 5 was hired on 2/7/25 and was currently employed at the facility.			

	The personnel file lacked documentation that Dietary Aide 5's applicable employee references had been conducted. During an interview on 4/16/25 at 11:20 a.m., the Executive Director indicated that the facility was unable to locate any documented references for QMA 7 and Dietary Aide 5. The employee files should have contained documentation that showed the employee references had been completed. On 4/16/25 at 12:20 p.m., the Executive Director provided a copy of the Personnel Records policy, dated January 2023, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...Personnel records on all employees will be kept in a central location in the community...the following documents will be retained in the personnel file...reference inquiry..."			
R 0120	Personnel - Noncompliance 410 IAC 16.2-5-1.4(e)(1-3) (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention,	R 0120	Facility ID: 005722 R120- Personnel Noncompliance 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	06/05/2025

	safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature.		No residents experienced adverse effects from the alleged deficient practice 2. 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? Alleged deficiency had the potential to affect all residents residing in the community. No residents had adverse effects related to the alleged deficient practice 3. What measures will be put in to place or what systematic changes will the facility make to ensure the deficient practice does not recur? The Executive Director or Designee will notify staff of any required training. Executive Director or Designee will remove any employees from the schedule who failed to comply with this requirement by the date set forth. 4. 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 in place? The Executive Director or designee will audit employee training weekly to ensure certified staff have completed required training on a timely	

	Based on interview and record review, the facility failed to ensure the required three hours annual dementia training was completed for 2 of 5 employee records reviewed. (QMA 8, QMA 9) Finding included: On 4/16/25 at 10:33 a.m., the employee records were reviewed. The employee records lacked dementia training for the following staff: - The employee record of QMA (Qualified Medication Aide) 8 indicated the date of hire was 8/1/19. The employee record lacked the required three hours of annual dementia training. - The employee record of QMA 9 indicated the date of hire was 3/2/22. The employee record lacked the required three hours of annual dementia training. During an interview on 4/16/25 at 12:25 p.m., the Executive Director indicated the facility was unable to provided documentation of the required annual dementia training. The Executive Director indicated the facility did not have a policy related to dementia training but followed the State guidelines regarding the required dementia training.		basis. Quality Assureance Committee (QA) will review audits monthly and make recommendations as needed By what date will the systematic changes be completed? 06/05/2025	

	Based on interview and record review, the facility failed to ensure the required three hours annual dementia training was completed for 2 of 5 employee records reviewed. (QMA 8, QMA 9) Finding included: On 4/16/25 at 10:33 a.m., the employee records were reviewed. The employee records lacked dementia training for the following staff: - The employee record of QMA (Qualified Medication Aide) 8 indicated the date of hire was 8/1/19. The employee record lacked the required three hours of annual dementia training. - The employee record of QMA 9 indicated the date of hire was 3/2/22. The employee record lacked the required three hours of annual dementia training. During an interview on 4/16/25 at 12:25 p.m., the Executive Director indicated the facility was unable to provided documentation of the required annual dementia training. The Executive Director indicated the facility did not have a policy related to dementia training but followed the State guidelines regarding the required dementia training.			

R 0121	Personnel - Noncompliance 410 IAC 16.2-5-1.4(f)(1-4) (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a	R 0121	Facility ID: 005722 R121-Personnel Noncompliance 1.What Corrective action(s) will be accomplished for the staff found to have been affected by the alleged deficient practice a b An audit of all employee files will be completed by the Business Office Manager. The employee files found to be out of compliance during the audit will have Physical Health screen completed checks on or before 06/05/2025 3.What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: a .The Business Office Manager will conduct an audit of employee files weekly for 4 weeks and	06/05/2025

	health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out. Based on interview and record review, the facility failed to maintain accurate personnel records and documentation of a physical health screening for 3 of 3 newly hired employees. (Dietary Aide 5, CNA 6, and QMA 7) Finding includes: On 4/16/25 at 10:00 a.m., the Executive Director provided a list of current employees with date of hire and associated position titles. On 4/16/25 at 10:55 a.m., the three newly hired employees' records were reviewed. The employee record documentation indicated the following: 1. Dietary Aide 5 was hired on 2/7/25 and was currently employed at the facility. 2. CNA 6 was hired on 2/21/25 and was currently employed at the facility.		monthly for 3 months. Variances will be corrected at the time of observation 4.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: a BOM and/ or ED to Results to be reviewed at monthly QI meetings and make further recommendations based off audit results. 5.By what date will the systematic changes be completed 06/05/2025	

	3. QMA (Qualified Medication Aide) 7 was hired on 4/7/25 and was currently employed at the facility. There were no records of an employee physical health screening for Dietary Aide 5, CNA 6, or QMA 7. During an interview on 4/16/25 at 11:30 a.m., the ED indicated that the physical health screenings for Dietary Aide 5, CNA 6, or QMA 7 could not be located and that the employees should have had the missing physical health screenings with their employee files. On 4/16/25 at 11:55 a.m., the ED indicated that they lacked a policy specific to physical health screens for newly hired employees and the facility followed State regulations and guidelines. Based on interview and record review, the facility failed to maintain accurate personnel records and documentation of a physical health screening for 3 of 3 newly hired employees. (Dietary Aide 5, CNA 6, and QMA 7) Finding includes:			

	On 4/16/25 at 10:00 a.m., the Executive Director provided a list of current employees with date of hire and associated position titles. On 4/16/25 at 10:55 a.m., the three newly hired employees' records were reviewed. The employee record documentation indicated the following: 1. Dietary Aide 5 was hired on 2/7/25 and was currently employed at the facility. 2. CNA 6 was hired on 2/21/25 and was currently employed at the facility. 3. QMA (Qualified Medication Aide) 7 was hired on 4/7/25 and was currently employed at the facility. There were no records of an employee physical health screening for Dietary Aide 5, CNA 6, or QMA 7. During an interview on 4/16/25 at 11:30 a.m., the ED indicated that the physical health screenings for Dietary Aide 5, CNA 6, or QMA 7 could not be located and that the employees should have had the missing physical health screenings with their employee files. On 4/16/25 at 11:55 a.m., the ED indicated that they lacked a policy specific to physical health screens for newly hired			

	employees and the facility followed State regulations and guidelines.			
R 0123	Personnel - Nonconformance 410 IAC 16.2-5-1.4(h)(1-10) (h) The facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (1) The name and address of the employee. (2) Social Security number. (3) Date of beginning employment. (4) Past employment, experience, and education, if applicable. (5) Professional licensure or registration number or dining assistant certificate or letter of completion, if applicable. (6) Position in the facility and job description. (7) Documentation of orientation to the facility, including residents' rights, and to the specific job skills. (8) Signed acknowledgement of orientation to residents' rights. (9) Performance evaluations in accordance with facility policy. (10) Date and reason for separation.	R 0123	Facility ID: 005722 R123-Personnel Noncompliance 1 What Corrective action(s) will be accomplished for the staff found to have been affected by the alleged deficient practice 2 How the facility will identify other staff having the potential to be affected by the same deficient practice and what corrective will be taken a An audit of all employee files will be completed by the Business Office Manager. The employee files found to be out of compliance during the audit will have 3 What measures will be put into place or what systemic changes the facility will make to ensure that the	06/05/2025

	Based on interview and record review, the facility failed to maintain accurate personnel records and documentation of general orientations, specific job orientations, or job descriptions for 2 of 3 newly hired employees. (Dietary Aide 5, CNA 6) Findings include: On 4/16/25 at 10:00 a.m., the Executive Director provided a list of current employees with date of hire and associated position titles. On 4/16/25 at 10:55 a.m., the three newly hired employees' records were reviewed. The employee record documentation indicated the following: 1. Dietary Aide 5 was hired on 2/7/25 and was currently employed at the facility. 2. CNA 6 was hired on 2/21/25 and was currently employed at the facility. The employee files lacked documentation that indicated the general orientations, specific job orientations, or job descriptions for Dietary Aide 5 and CNA 6 had been provided to the employee. During an interview on 4/16/25 at 11:30 a.m., the ED indicated that the job orientations and job descriptions for Dietary Aide 5		deficient practice does not recur: a .The Business Office Manager will conduct an audit of employee files weekly for 4 weeks and monthly for 3 months. Variances will be corrected at the time of observation 4 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: b BOM and/ or ED to Results to be reviewed at monthly QI meetings and make further recommendations based off audit results. 5 By what date will the systematic changes be completed: 06/05/2025	

	and CNA 6 could not be located and that the employees should have had the missing documentation with their employee files. On 4/16/25 at 11:33 a.m., the ED provided a copy of a policy titled "General Orientation", dated effective April 2021, and indicated it was the policy currently in use by the facility. A review of the policy indicated that the general orientation process included job descriptions and both general and specific orientation to be completed no later than the 30th day of employment. Based on interview and record review, the facility failed to maintain accurate personnel records and documentation of general orientations, specific job orientations, or job descriptions for 2 of 3 newly hired employees. (Dietary Aide 5, CNA 6) Findings include: On 4/16/25 at 10:00 a.m., the Executive Director provided a list of current employees with date of hire and associated position titles. On 4/16/25 at 10:55 a.m., the three newly hired employees' records were reviewed. The employee record documentation indicated the following:			

	1. Dietary Aide 5 was hired on 2/7/25 and was currently employed at the facility. 2. CNA 6 was hired on 2/21/25 and was currently employed at the facility. The employee files lacked documentation that indicated the general orientations, specific job orientations, or job descriptions for Dietary Aide 5 and CNA 6 had been provided to the employee. During an interview on 4/16/25 at 11:30 a.m., the ED indicated that the job orientations and job descriptions for Dietary Aide 5 and CNA 6 could not be located and that the employees should have had the missing documentation with their employee files. On 4/16/25 at 11:33 a.m., the ED provided a copy of a policy titled "General Orientation", dated effective April 2021, and indicated it was the policy currently in use by the facility. A review of the policy indicated that the general orientation process included job descriptions and both general and specific orientation to be completed no later than the 30th day of employment.			

R 0273	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(f) (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to ensure foods were served in a sanitary and safe manner for 1 of 3 kitchen observations. Staff hair was not covered while in the kitchen food preparation area. (Cook 2) Finding includes: During the initial kitchen observation on 4/15/25 from 9:15 a.m. to 9:35 a.m., a sign was observed hanging on the kitchen's entry door. A review of the sign indicated, "Hair nets must be worn in the kitchen at all times." During a follow-up kitchen observation on 4/15/25 from 12:45 p.m. to 12:50 p.m., the following was observed: - Cook 2 was observed at the food preparation table located near the steam table where the noon meal was being plated. Cook 2 was observed preparing the meat for the evening meal. Cook 2 was observed wearing a	R 0273	R273-Personnel-Noncompliance 1.What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice residents experienced adverse effects from the alleged deficient practice. 2.How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken a.All residents that dine from the kitchen had the potential to be affected by the alleged deficient practice. The Dietary Manager or designee will provide an in-service to all kitchen staff regarding the use of facial hair coverings 3.What measures will be put into	06/05/2025

hair net that covered hair from the top of his ears to the top of his head. Cook 2's hair, approximately one-half inch in length, from below the hair net to the neckline was observed to not be covered. Cook 2 was observed to have hair, approximately one-half inch in length, in front of both ears and had facial hair that covered the cheek bone area to the jaw line, including hair above and below the lips. Cook 2's facial hair was observed to not be covered.

During an interview on 4/15/25 at 12:55 p.m., the Dietary Manager indicated Cook 2's hair should have been covered.

During an interview on 4/15/25 at 12:57 p.m., Cook 2 indicated all hair was to be covered while in the kitchen.

On 4/15/25 at 1:30 p.m., the Executive Director provided a copy of the Culinary Dress Code and Requirements, dated July 2024, and indicated it was the current policy in use by the facility. A review of the document indicated, "...hair must be restrained...hairnets must be worn in the kitchen while preparing food...beardnets must be worn..."

On 4/15/25 at 3:30 p.m., a review of the Indiana Food Establishment Sanitation Requirements, Title 410 IAC

place or what systemic changes the facility will make to ensure that the
deficient practice does not recur:

a An in-service will be held by the Dietary
Manager or designee to include all kitchen staff. Any staff member out of compliance with facility's policies and protocols relating to facial coverings will receive progressive corrective action.
The Dietary Manager or designee will educate all newly hired clinical staff on
policies and protocols relating to hair coverings

4.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:

a The Dietary Manager or designee will audit
the use of facial coverings daily for two (2) weeks, then two (2) times a week
for two (2) weeks, and then weekly for three (3) weeks, then as needed to
ensure that the proper

	7-24, effective November 13, 2004, indicated, "...food employees shall wear hair restraints, such as hats, hair coverings or nets...that are designed and worn to effectively keep their hair from contacting...exposed food..." Based on observation, interview, and record review, the facility failed to ensure foods were served in a sanitary and safe manner for 1 of 3 kitchen observations. Staff hair was not covered while in the kitchen food preparation area. (Cook 2) Finding includes: During the initial kitchen observation on 4/15/25 from 9:15 a.m. to 9:35 a.m., a sign was observed hanging on the kitchen's entry door. A review of the sign indicated, "Hair nets must be worn in the kitchen at all times." During a follow-up kitchen observation on 4/15/25 from 12:45 p.m. to 12:50 p.m., the following was observed: - Cook 2 was observed at the food preparation table located near the steam table where the noon meal was being plated. Cook 2 was observed preparing the meat for the evening meal. Cook 2 was observed wearing a hair net that covered hair from the top of his ears to the top of his head. Cook 2's hair,		procedure is properly executed. Results to be reviewed at monthly QI meetings and make further recommendations based on audit results. 5 By what date will the systematic changes be completed 06/05/2025	

approximately one-half inch in length, from below the hair net to the neckline was observed to not be covered. Cook 2 was observed to have hair, approximately one-half inch in length, in front of both ears and had facial hair that covered the cheek bone area to the jaw line, including hair above and below the lips. Cook 2's facial hair was observed to not be covered.

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On 4/15/25 at 3:30 p.m., a review of the Indiana Food Establishment Sanitation Requirements, Title 410 IAC 7-24, effective November 13, 2004, indicated, "...food employees shall wear hair

	restraints, such as hats, hair coverings or nets...that are designed and worn to effectively keep their hair from contacting...exposed food..."			

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 SIGNATURE	TITLE	(X6) DATE