STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROWNPOINTE OF INDIANAPOLIS	7365 E 16TH ST, INDIANAPOLIS, , 46219

(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 467294. Intake 467294 - State deficiencies related to the allegations are cited at R240, R297, and R349. Survey date: 2/3/26 Facility number: 005729 Residential Census: 39 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on February 9, 2026.	R 0000	Preparation and or execution of This Plan of Correction in general or any correct set forth herein, in particular, does not constituent admission or agreement by CrownPointe of the facts alleged or the conclusion set forth in the statement of deficiencies. The Plan of Correction and specific corrective actions are prepared and/or executed solely because the provisions of the Federal and State/laws. CrownPointe desires the Plan of Correction to be considered the facility's allegation of compliance.	

R 0240	Health Services - Deficiency 410 IAC 16.2-5-4(d) (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on interview and record review, the facility failed to ensure blood pressure medications that were ordered with parameters were clarified with the physician and administered as ordered for 1 of 3 residents reviewed for Health Services. (Resident B) Findings include: The clinical record for Resident B was reviewed on 2/3/26 at 9:45 a.m. A physician's order, dated 11/4/25, indicated Resident B was to receive 5 milligrams of amlodipine besylate daily. The staff were call the physician if the residents systolic blood pressure (top number-heart at work) reading was greater than 160 or the resident's heart rate was less than 60. A physician's order, dated 11/18/25, indicated staff were to obtain the resident's blood pressure readings due to the administration of blood pressure medications. The staff were to hold the resident's amlodipine blood pressure medication if the	R 0240	• Resident B's record was reviewed. The attending physician was notified, and the blood pressure parameters were clarified to clearly state that medication is to be held if the systolic blood pressure is less than 110 OR diastolic blood pressure is less than 60 OR heart rate is less than 60. • A clarified physician order was obtained and implemented. Resident B was assessed for any adverse effects; none were identified. • Licensed nursing staff were immediately re-educated on following physician-ordered medication parameters and proper documentation of blood pressure and heart rate prior to administration. • The Director of Nursing conducted an audit of all residents receiving antihypertensive medications with ordered parameters. • The audit included review of physician orders for clarity, review of the last 30 days of MARs for compliance with hold parameters.	02/22/2026

	resident's systolic blood pressure was less than 110, and diastolic blood pressure was less than 60 ,or the heart rate was less than 60.
	
	The December 2025 Medication Administration Record (MAR) indicated on the following dates the resident's blood pressure readings were out of the administration parameters and staff administered the resident's 5 milligrams of amlodipine besylate:
	
	-On 12/4/25, the resident's blood pressure reading was 96/52. The staff administered the resident 5 milligrams of amlodipine besylate.
	
	- On 12/20/25, the resident's blood pressure reading was 95/55. The staff administered the resident 5 milligrams of amlodipine besylate.
	
	-On 12/26/25, the resident's blood pressure reading was 108/55. The staff administered the resident 5 milligrams of amlodipine besylate.
	
	The December 2025 and January 2026 MARs did not include a recorded heart rate for the resident for the administration of the resident's amlodipine blood pressure medications.
	
	An interview was conducted
			• Any discrepancies identified were corrected immediately, clarified with the physician if needed, and staff were re-educated.
			
			• All medication orders containing administration parameters will be reviewed upon receipt for clarity. Any unclear orders will be clarified with the physician within 24 hours.
			• All staff that administer medications have been re-educated.
			
			• The DON or designee will audit 5 residents weekly for 4 weeks who receive antihypertensive medications with parameters.
			• Audits will include verification that:
			  • Vital signs documented as ordered
			  • Medications are held when parameters are not met
			  • Physician notification occurs when required
			• After 4 weeks, audits will be conducted monthly for 2 additional months. Any identified noncompliance will result in immediate corrective action and	

	with the Director of Nursing on 2/3/26 at 1:21 p.m. She indicated the staff should have been administering the resident's amlodipine besylate medication per the physician's parameters as ordered. She understood the physician's order as if both the systolic and diastolic blood pressure readings were not within the parameters to hold the blood pressure medication. The physician's order for the blood pressure parameters should have been clarified, because with some of the resident's lower systolic blood pressure readings the staff should have held the resident's amlodipine medication. This citation relates to Intake 467294. Based on interview and record review, the facility failed to ensure blood pressure medications that were ordered with parameters were clarified with the physician and administered as ordered for 1 of 3 residents reviewed for Health Services. (Resident B) Findings include: The clinical record for Resident B was reviewed on 2/3/26 at 9:45 a.m. A physician's order, dated 11/4/25, indicated Resident B was to receive 5 milligrams of amlodipine		additional staff re-education. Plan of correction will be implemented on or before 2/22/2026.	

	besylate daily. The staff were call the physician if the residents systolic blood pressure (top number-heart at work) reading was greater than 160 or the resident's heart rate was less than 60. A physician's order, dated 11/18/25, indicated staff were to obtain the resident's blood pressure readings due to the administration of blood pressure medications. The staff were to hold the resident's amlodipine blood pressure medication if the resident's systolic blood pressure was less than 110, and diastolic blood pressure was less than 60 ,or the heart rate was less than 60. The December 2025 Medication Administration Record (MAR) indicated on the following dates the resident's blood pressure readings were out of the administration parameters and staff administered the resident's 5 milligrams of amlodipine besylate: -On 12/4/25, the resident's blood pressure reading was 96/52. The staff administered the resident 5 milligrams of amlodipine besylate.			

	- On 12/20/25, the resident's blood pressure reading was 95/55. The staff administered the resident 5 milligrams of amlodipine besylate. -On 12/26/25, the resident's blood pressure reading was 108/55. The staff administered the resident 5 milligrams of amlodipine besylate. The December 2025 and January 2026 MARs did not include a recorded heart rate for the resident for the administration of the resident's amlodipine blood pressure medications. An interview was conducted with the Director of Nursing on 2/3/26 at 1:21 p.m. She indicated the staff should have been administering the resident's amlodipine besylate medication per the physician's parameters as ordered. She understood the physician's order as if both the systolic and diastolic blood pressure readings were not within the parameters to hold the blood pressure medication. The physician's order for the blood pressure parameters should have been clarified, because with some of the resident's lower systolic blood pressure readings the staff should have held the resident's amlodipine medication.			

	This citation relates to Intake 467294.			
R 0297	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(c)(1) (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana. Based on interview and record review, the facility failed to ensure the availability of medications to administer for 2 of 3 residents reviewed for medications. (Resident B and Resident C) Findings include: 1.The clinical record for Resident B was reviewed on 2/3/26 at 9:45 a.m. The diagnoses included, but were not limited to, anxiety disorder. A service plan, dated 12/16/25, indicated Resident B was "alert, oriented-makes sound independent decisions." A physician's order, dated	R 0297	• Residents B and C's eMAR were immediately reviewed. The attending physicians were notified of missed doses related to unavailable medications. Both residents were assessed for adverse effects related to missed doses; no new physician orders were issued at that time. • The facility immediately contacted the pharmacy to ensure all current medications were supplied without further interruption. • Licensed nursing staff were re-educated on timely medication reordering procedures and monitoring medication supply levels. • The Director of Nursing (DON) or designee conducted an audit of all residents' MARs for the past 30 days to identify missed medications due to "unavailable" or pharmacy delay. • Any identified missed doses were reviewed with the physician and pharmacy as appropriate.	02/22/2026

	11/24/25, indicated Resident B was to receive 0.5 milligrams of alprazolam (used for the short term treatment of generalized aniety) daily. This order was discontinued on 12/26/25.
	
	A physician's order, dated 12/26/25, indicated Resident B was to receive 0.5 milligrams of alprazolam daily.
	
	A physician's order, dated 12/20/25, indicated Resident B was to receive 100 milligrams of pregabalin (used primarily for nerve pain) four times a day. The medication was discontinued and rewritten on 1/20/26.
	
	A physician's order, dated 1/20/26, indicated Resident B was to receive 100 milligrams of pregabalin four times a day.
	
	The December 2025 Medication Administration Record (MAR) for Resident B indicated the following days and times the resident did not receive the 0.5 milligrams of the alprazolam daily or the 100 milligrams of pregabalin four times a day due to unavailable medications. The staff were waiting for medications to be delivered by pharmacy:
	
	On 12/24/25, 12/25/25, 12/26/25 and 12/27/25, the resident did not receive the 0.5 milligrams of alprazolam due to
			Immediate corrective action was taken to ensure adequate medication supply for any affected residents.
			
			• Medications will be reordered when a 7-day supply remains.
			• If medications are not delivered timely, the facility will utilize the EDK to obtain medications, as available.
			• Nurses and QMAs have received mandatory in-service education on medication reordering procedures, EDK procedure, and documentation requirements.
			
			• The DON or designee will conduct weekly audits for 4 weeks of:
			  • Medication carts for adequate supply
			  • MARs for documentation of missed doses due to “unavailable”
			  • Timeliness of medication reorders	

	unavailable. On 12/4/25 at 6:00 p.m. ;and on 12/5/25 at 12:00 a.m. and 6:00 a.m. the resident did not receive the 100 milligrams of pregabalin due to not available. The January 2026 MAR for Resident B indicated the following days and times the resident did not receive the 100 milligrams of pregabalin four times a day due to unavailable medications. The facility was waiting for the medications to be delivered by pharmacy: -On 1/5/26 at 12:00 p.m. and 6:00 p.m., the resident did not receive the100 milligrams of pregabalin due to unavailable. -On 1/6/26 through 1/20/26 at 12:00 a.m., 6:00 a.m., 12:00 p.m., and 6:00 p.m., the resident did not receive the100 milligrams of pregabalin due to unavailable. -On 1/21/26 at 12:00 a.m., 6:00 a.m., and 12:00 p.m., the resident did not receive the100 milligrams of pregabalin due to unavailable. An interview was conducted with Resident B on 2/3/26 at 10:29 a.m. She indicated the facility ran out of her medications often. She was unsure if they wait too long to reorder the medications or		• After 4 weeks, audits will be conducted monthly for 2 additional months. Any identified noncompliance will result in immediate corrective action and additional staff re-education. Plan of correction will be implemented on or before 2/22/2026.	

	pharmacy issues. She has went a week without her Xanax. She had anxiety and could tell when she did not get her medications. 2. The clinical record for Resident C was reviewed on 2/3/26 at 10:30 a.m. The resident's diagnosis included, but was not limited to, cervical disc disorder (breakdown of the cushioning discs in the neck). A service plan, dated 11/10/25, indicated the resident was alert and oriented. She was unable to take medications unless administered by someone else. A physician's order, dated 11/22/25, indicated the resident was to receive tramadol HCL (narcotic pain medication) 50 milligram (mg) one tablet by mouth four times a day. The December 2025 MAR indicated Resident C did not receive her tramadol 50 mg on the following days: 12/26/25 and 12/27/25 due to awaiting pharmacy to deliver. The January 2026 MAR indicated Resident C did not receive her tramadol 50 mg on the following days: 1/4/26, 1/5/26, and 1/6/26 due to awaiting pharmacy to deliver. During an interview, on 2/3/26 at 11:20 a.m., Resident C indicated the facility ran out of			

	her narcotic medications sometimes. Her pain increased when she did not receive her narcotic medications. The facility would give her Tylenol to try to help with the pain. An interview was conducted with the Director of Nursing (DON) on 2/3/26 at 2:07 p.m. She indicated the facility was having trouble with the pharmacy refilling medications requiring prior authorizations from the insurances. It had been difficult and there had been delays with providing medications to the residents due to not receiving the medication supply from the pharmacy timely. A pharmacy distribution policy was provided by the DON on 1/3/26 at 3:07 p.m. It indicated, "Pharmacy Standards...Pharmacy must abide by Federal, State and Local guidelines...Emergency orders, new prescriptions, or changes in a prescription are to be delivered within a reasonable amount of time so facility is compliant with physician's order and resident's health is not jeopardized. If in some circumstances this cannot be met the Pharmacy will contact the facility and assist in getting the prescription filled at a local Pharmacy..."			

	This citation relates to Intake 467294. Based on interview and record review, the facility failed to ensure the availability of medications to administer for 2 of 3 residents reviewed for medications. (Resident B and Resident C) Findings include: 1.The clinical record for Resident B was reviewed on 2/3/26 at 9:45 a.m. The diagnoses included, but were not limited to, anxiety disorder. A service plan, dated 12/16/25, indicated Resident B was "alert, oriented-makes sound independent decisions." A physician's order, dated 11/24/25, indicated Resident B was to receive 0.5 milligrams of alprazolam (used for the short term treatment of generalized aniety) daily. This order was discontinued on 12/26/25. A physician's order, dated 12/26/25, indicated Resident B was to receive 0.5 milligrams of alprazolam daily. A physician's order, dated 12/20/25, indicated Resident B was to receive 100 milligrams of pregabalin (used primarily for nerve pain) four times a day. The medication was			

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R 0349	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(a)(1-4) (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on interview and record review, the facility failed to ensure closely monitoring and accurately documenting in the resident's controlled drug record sheets for 1 of 3 residents reviewed for medications. (Resident B) Findings include: The clinical record for Resident B was reviewed on 2/3/26 at 9:45 a.m. The resident's diagnosis included, but was not limited to, anxiety disorder. A service plan, dated 12/16/25, indicated Resident B was "alert, oriented-makes sound independent decisions." A physician's order, dated	R 0349	• Resident B's controlled drug records and eMARs were immediately reviewed for accuracy and reconciliation. A full narcotic count was completed, and discrepancies were investigated. • The two alprazolam tablets that were unaccounted for were located in the medication cart and properly destroyed per facility policy with appropriate documentation. • Resident B was assessed for any adverse effects related to documentation discrepancies; no negative outcomes were identified. • Licensed nursing staff involved received immediate re-education on proper controlled substance documentation, narcotic count procedures, and accurate date/time recording. • The Director of Nursing (DON) or designee conducted a 100% audit of all controlled drug records for the past 30 days.	02/22/2026

	11/24/25, indicated Resident B was to receive 0.5 milligrams of alprazolam (used for the short term treatment of generalized aniety) daily. This order was discontinued on 12/26/25. A physician's order, dated 12/26/25, indicated Resident B was to receive 0.5 milligrams of alprazolam daily. A physician's order, dated 12/20/25, indicated Resident B was to receive 100 milligrams of pregabalin (used primarily for nerve pain) four times a day. The medication was discontinued and rewritten on 1/20/26. A physician's order, dated 1/20/26, indicated Resident B was to receive 100 milligrams of pregabalin four times a day. The medication was to be administered at 12:00 a.m., 6:00 a.m., 12:00 p.m., and 6:00 p.m. The December 2025 Medication Administration Record for Resident B indicated the resident received 0.5 alprazolam daily from 12/1/25 through 12/23/25. The December 2025 "Controlled Drug Record" for the Resident B's 0.5 milligrams of alprazolam indicated the resident had received the medication on 12/1/25 and 12/2/25 at 8:00 a.m. and 6:00 p.m. The narcotic		• The audit included: • Verification of accurate shift-to-shift narcotic counts • Matching MAR documentation to controlled drug records • Verification of signatures, dates, times, and remaining counts • Any discrepancies identified were immediately reconciled, investigated, and corrected. Staff responsible for errors received re-education. • Mandatory re-education for all nurses and QMAs on controlled substance documentation and reconciliation procedures. • The DON or designee will complete a weekly random audit of controlled drug records. • Any documentation error identified must be corrected before the end of the shift and reported to the DON. • Reinforcement of the facility's Clinical Documentation Policy to ensure records are complete, accurate, and systematically organized. • The DON or designee will conduct weekly audits of	

	count was 21 left after those dosages were given. On 12/3/25 at 8:00 a.m. a dosage was documented as removed and a line was placed across the removal of the dosage and narcotic count of 20 remaining as an error had occurred. A documented narcotic remaining count of 21 was indicated at that time on the record as of 12/3/25. The next dosage on 12/4/25 at 8:00 a.m. was documented as the dosage was removed at that time with the remaining count after the removal was 19. An additional dosage was documented on 12/4/25 at 6:00 p.m. a dosage was removed and the remaining was 18. On 12/5/25 at 8:00 a.m. a dosage was removed and the remaining count was 18. On 12/6/25 at 8:00 a.m. a dosage was removed and the remaining count was 17. The 12/7/25 dosage at 8:00 a.m. indicated the dosage was removed and the remaining was 16. On 12/8/25 at 8:00 a.m. and 12/9/25 at 8:00 a.m. one dosage was removed on each day and the total remaining was 14 remaining after those dosages. A "Controlled Drug Record" for 0.5 milligrams alprazolam, dated 12/9/25 through 12/23/25, indicated on 12/9/25 there were a supply of 15 dosages of 0.5 milligrams of alprazolam		controlled drug records for 4 weeks to ensure: • Accurate narcotic counts • Proper signatures for each dose removed • Correct date and time documentation • Reconciliation between MAR and controlled drug records • After 4 weeks, audits will be conducted monthly for 2 additional months. Any identified noncompliance will result in immediate corrective action and additional staff re-education. Plan of correction will be implemented on or before 2/22/2026.	

medications for Resident B. That record also indicated on 12/9/25 one dosage was given that day. The remaining amount was 14 alprazolam medications after that dosage was given.

The January 2026 Medication Administration Record for Resident B indicated the resident received 100 milligrams of pregabalin four times a day from 1/21/26 through 1/31/26.

The January 2026 "Controlled Drug Record" for the 100 milligrams of pregabalin indicated on 1/22/26, the staff did not sign the removal of the 12:00 p.m. pregabalin dose. On 1/26/26 and 1/27/26, the record was dated and timed incorrectly. The record indicated the following dosages: 1/26/26 at 12:00 a.m., 1/26/26 at 6:00 a.m., 1/26/26 at 12:00 p.m., 1/27/26 at 6:00 p.m. 1/27/26 at 12:00 p.m., 1/27/26 at 6:00 a.m., 1/27/26 at 12:00 p.m., and 1/27/26 at 6:00 p.m.

An interview was conducted with the Director of Nursing on 2/3/26 at 1:21 p.m. She indicated she had recognized and aware the narcotic record keeping for the narcotics were "poorly" kept by the staff after she completed an audit. She provided education to the staff how to keep good records of narcotics. After review of the January controlled drug record

for the resident's 100 milligrams of pregabalin, she was unaware of Resident B missing a noon dosage on 1/22/26. The staff were unable to locate two dosages of Resident B's 0.5 milligrams of alprazolam medications, but she was able to locate them. They were in the medication cart. Another supply of 0.5 milligrams of alprazolam had arrived from pharmacy, so the resident did not miss any dosages. The DON destroyed the two located alprazolam medications. She continues to work with the staff with record keeping of narcotic medications.

A clinical documentation policy was provided by the Director of Nursing on 2/3/26 at 3:07 p.m. It indicated, "Policy: It is the policy of this facility to ensure sufficient documentation in each resident medical record. The records must be complete, accurately documented, readily accessible and systematically organized..."

This citation relates to Intake 467294.

Based on interview and record review, the facility failed to ensure closely monitoring and accurately documenting in the resident's controlled drug record sheets for 1 of 3 residents reviewed for medications. (Resident B)

Findings include:

The clinical record for Resident B was reviewed on 2/3/26 at 9:45 a.m. The resident's diagnosis included, but was not limited to, anxiety disorder.

A service plan, dated 12/16/25, indicated Resident B was "alert, oriented-makes sound independent decisions."

A physician's order, dated 11/24/25, indicated Resident B was to receive 0.5 milligrams of alprazolam (used for the short term treatment of generalized aniety) daily. This order was discontinued on 12/26/25.

A physician's order, dated 12/26/25, indicated Resident B was to receive 0.5 milligrams of alprazolam daily.

A physician's order, dated 12/20/25, indicated Resident B was to receive 100 milligrams of pregabalin (used primarily for nerve pain) four times a day. The medication was discontinued and rewritten on 1/20/26.

A physician's order, dated 1/20/26, indicated Resident B was to receive 100 milligrams of pregabalin four times a day. The medication was to be administered at 12:00 a.m., 6:00 a.m., 12:00 p.m., and 6:00 p.m.

The December 2025 Medication Administration Record for Resident B indicated the resident received 0.5 alprazolam daily from 12/1/25 through 12/23/25.

The December 2025 "Controlled Drug Record" for the Resident B's 0.5 milligrams of alprazolam indicated the resident had received the medication on 12/1/25 and 12/2/25 at 8:00 a.m. and 6:00 p.m. The narcotic count was 21 left after those dosages were given. On 12/3/25 at 8:00 a.m. a dosage was documented as removed and a line was placed across the removal of the dosage and narcotic count of 20 remaining as an error had occurred. A documented narcotic remaining count of 21 was indicated at that time on the record as of 12/3/25. The next dosage on 12/4/25 at 8:00 a.m. was documented as the dosage was removed at that time with the remaining count after the removal was 19. An additional dosage was documented on 12/4/25 at 6:00 p.m. a dosage was removed and the remaining was 18. On 12/5/25 at 8:00 a.m. a dosage was removed and the remaining count was 18. On 12/6/25 at 8:00 a.m. a dosage was removed and the remaining count was 17. The 12/7/25 dosage at 8:00 a.m. indicated the dosage was removed and

the remaining was 16. On 12/8/25 at 8:00 a.m. and 12/9/25 at 8:00 a.m. one dosage was removed on each day and the total remaining was 14 remaining after those dosages.

A "Controlled Drug Record" for 0.5 milligrams alprazolam, dated 12/9/25 through 12/23/25, indicated on 12/9/25 there were a supply of 15 dosages of 0.5 milligrams of alprazolam medications for Resident B. That record also indicated on 12/9/25 one dosage was given that day. The remaining amount was 14 alprazolam medications after that dosage was given.

The January 2026 Medication Administration Record for Resident B indicated the resident received 100 milligrams of pregabalin four times a day from 1/21/26 through 1/31/26.

The January 2026 "Controlled Drug Record" for the 100 milligrams of pregabalin indicated on 1/22/26, the staff did not sign the removal of the 12:00 p.m. pregabalin dose. On 1/26/26 and 1/27/26, the record was dated and timed incorrectly. The record indicated the following dosages: 1/26/26 at 12:00 a.m., 1/26/26 at 6:00 a.m., 1/26/26 at 12:00 p.m., 1/27/26 at 6:00 p.m. 1/27/26 at 12:00 p.m., 1/27/26 at 6:00 a.m., 1/27/26 at 12:00 p.m., and

	1/27/26 at 6:00 p.m. An interview was conducted with the Director of Nursing on 2/3/26 at 1:21 p.m. She indicated she had recognized and aware the narcotic record keeping for the narcotics were "poorly" kept by the staff after she completed an audit. She provided education to the staff how to keep good records of narcotics. After review of the January controlled drug record for the resident's 100 milligrams of pregabalin, she was unaware of Resident B missing a noon dosage on 1/22/26. The staff were unable to locate two dosages of Resident B's 0.5 milligrams of alprazolam medications, but she was able to locate them. They were in the medication cart. Another supply of 0.5 milligrams of alprazolam had arrived from pharmacy, so the resident did not miss any dosages. The DON destroyed the two located alprazolam medications. She continues to work with the staff with record keeping of narcotic medications. A clinical documentation policy was provided by the Director of Nursing on 2/3/26 at 3:07 p.m. It indicated, "Policy: It is the policy of this facility to ensure sufficient documentation in each resident medical record. The records must be complete, accurately documented, readily accessible			

	and systematically organized..." This citation relates to Intake 467294.			

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 SIGNATUREAndrea Wilson	TITLERCA	(X6) DATE02/17/2026