STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OASIS AT 56TH	4940 WEST 56TH STREET, INDIANAPOLIS, , 46254

(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 Complaints IN00366365 and IN00365568. Complaint IN00366365 - Substantiated. State Residential Findings related to the allegations are cited at R217 and R241. Complaint IN00365568 - Substantiated. State Residential Findings related to the allegations are cited at R006, R090, R217 and R241. Survey date: November 10, 2021 Facility number: 014279 Residential Census: 106 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on November 19, 2021	R 0000	12/06/2021 POC Complaints (IN00365568, IN00366365) November 10, 2021 I would respectively request a desk review.	

R 0006	Scope of Residential Care - Deficiency 410 IAC 16.2-5-0.5(f)(1-5) (f) The resident must be discharged if the resident: (1) is a danger to the resident or others; (2) requires twenty-four (24) hour per day comprehensive nursing care or comprehensive nursing oversight; (3) requires less than twenty-four (24) hour per day comprehensive nursing care, comprehensive nursing oversight, or rehabilitative therapies and has not entered into a contract with an appropriately licensed provider of the resident ' s choice to provide those services; (4) is not medically stable; or (5) meets at least two (2) of the following three (3) criteria unless the resident is medically stable and the health facility can meet the resident ' s needs: (A) Requires total assistance with eating. (B) Requires total assistance with toileting. (C) Requires total assistance with transferring. Based on observation, interview, and record review, the facility failed to timely discharge	R 0006	R006 -**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident no longer lives at this community. -**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** No other resident was affected by this deficient practice -**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Residents will be re-assessed by DON/designee per policy before returning to	12/04/2021

	a resident who required long term care placement and maximum assistance for activities of daily living for 1 of 2 residents reviewed for catheter care. (Resident C) Findings include: The clinical record for Resident C was reviewed on 11/10/21 at 10:47 a.m. The diagnoses included, but were not limited to: type 2 diabetes, neuromuscular dysfunction of bladder, and osteoarthritis. She was admitted to the facility on 7/7/21. The 5/24/21 Initial Assessment indicated she needed assistance with bathing, dressing, meals/eating, laundry, housekeeping, walking/locomotion, standing, transfers, managing medications, transportation, shopping and finances. She had dentures, used a nebulizer, catheter, and wheel chair, had a history of falls, and had received the first dose of her covid vaccination. She required "GL shots to knees Q [every] 3 months." An interview and observation was conducted with Resident C on 11/10/21 at 12:29 p.m. She was lying in bed. Her catheter bag was hanging along the side of her bed. She indicated her catheter needed changed, as it had been over a month since it		community. If resident is not appropriate for our assisted living, discharge plans will begin immediately to find a community to meet the needs of the resident. -**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.** This process will be reviewed by DON/designee, IDT Team, and Administrator weekly for 8 weeks, monthly for 4 months and then as needed. At the monthly QA meetings, the results of the monitoring will be reviewed. Any patterns will be identified. If indicated, an Action Plan will be written by the QA Committee. Any Action Plan will be reviewed weekly by the Administrator until resolved. Any concerns will be addressed as discovered. -**By what date the**	

	was last changed, and it was supposed be changed every 30 days. The aides emptied the bag, but nursing did not change the catheter, regularly assess or clean the site, or change the bag. She only had 2 showers since admitted, because it was difficult to transfer her. The facility did not have a lift to transfer her, so they would put her on the side of the bed to transfer her, but it hurt to be transferred that way. If she had more help, she could get into the shower, but also needed a shower chair. Pain patches were ordered for her leg, but she never received them. She required shots to her knees every 3 months, but hadn't gotten them in 4 months. There was no one to get her to appointments from this facility, as she needed to go out via stretcher. She also never received her 2nd covid vaccination. She wanted to go to a different facility where she could get more assistance. She stated, "I'm not supposed to be here." An interview was conducted with CNA (Certified Nursing Assistant) 5 on 11/10/21 at 3:45 p.m. She indicated she'd worked at the facility for a year and a half. Resident C just stayed in bed. She used to be able to transfer herself, but they were told not to transfer her anymore, and it had "been		**systematic changes will be completed** December 4, 2021	

	months" since she'd transferred her. The only time she was out of bed was for therapy, and to her knowledge, therapy was the only one to transfer her. She was unsure how they transferred her, and there were no mechanical lifts in the facility. She stated, "She's just in her room watching TV. She belongs in long term care. I thought she was supposed to move, but I don't know what happened with that." An interview was conducted with the Therapy Director on 11/10/21 at 3:53 p.m. She indicated Resident C hadn't been to therapy since 10/12/21, and that would have been the last time anyone from therapy transferred her from her bed. Resident C's POA (Power of Attorney) situation was inconsistent. Her current POA had a power wheel chair and some furniture for her, but it never made it's way to the facility. An interview was conducted with the ED (Executive Director) on 11/10/21 at 12:58 p.m. She indicated they attempted to transfer her to a different facility, but she did not get accepted. She thought they were working on getting her into another one. An interview was conducted with the DON (Director of Nursing) on 11/10/21 at 3:17			

	p.m. She indicated she informed Resident C's court appointed POA that, "She needs to get out of here." They were in the process of sending paperwork to a potential facility, but there was some confusion with who would be taking over responsibility for overseeing her care. Resident C had been to the hospital twice in the last month or so, but she hadn't thought about having her go into long term care straight from the hospital. Her catheter should be changed monthly, but was unsure when it was last changed. There should be catheter care orders. If there were issues with her catheter, they sent her to the hospital. As far as appointments, they would set up transportation, if they knew she had one scheduled. She was unaware of her needing shots for her knees or needing her second covid vaccination shot. Resident C received home health services, but she wasn't sure by which provider. She stated, "There's a huge breakdown in communication between home health and nursing," and there was no process in place to coordinate care between them. On 9/29/21 at 12:15 p.m., the DON provided the Residency Admission and Tenancy Requirements Policy, dated 2/2021, which read "...The community is licensed as a			

Residential Care Facility...As such, each resident of The Community must satisfy all of the following conditions for admission and residency: Each resident must be capable of self-preservation and independent daily living with assistance...The Community does not provide continuous intermediate or skilled nursing level of care and is not a 'comprehensive care facility'..."

This Residential Tag relates to Complaint IN00365568.

Based on observation, interview, and record review, the facility failed to timely discharge a resident who required long term care placement and maximum assistance for activities of daily living for 1 of 2 residents reviewed for catheter care. (Resident C)

Findings include:

The clinical record for Resident C was reviewed on 11/10/21 at 10:47 a.m. The diagnoses included, but were not limited to: type 2 diabetes, neuromuscular dysfunction of bladder, and osteoarthritis. She was admitted to the facility on 7/7/21.

The 5/24/21 Initial Assessment indicated she needed assistance with bathing, dressing, meals/eating, laundry, housekeeping, walking/locomotion, standing,

transfers, managing medications, transportation, shopping and finances. She had dentures, used a nebulizer, catheter, and wheel chair, had a history of falls, and had received the first dose of her covid vaccination. She required "GL shots to knees Q [every] 3 months."

An interview and observation was conducted with Resident C on 11/10/21 at 12:29 p.m. She was lying in bed. Her catheter bag was hanging along the side of her bed. She indicated her catheter needed changed, as it had been over a month since it was last changed, and it was supposed be changed every 30 days. The aides emptied the bag, but nursing did not change the catheter, regularly assess or clean the site, or change the bag. She only had 2 showers since admitted, because it was difficult to transfer her. The facility did not have a lift to transfer her, so they would put her on the side of the bed to transfer her, but it hurt to be transferred that way. If she had more help, she could get into the shower, but also needed a shower chair. Pain patches were ordered for her leg, but she never received them. She required shots to her knees every 3 months, but hadn't gotten them in 4 months. There was no one to get her to appointments from this facility,

	as she needed to go out via stretcher. She also never received her 2nd covid vaccination. She wanted to go to a different facility where she could get more assistance. She stated, "I'm not supposed to be here." An interview was conducted with CNA (Certified Nursing Assistant) 5 on 11/10/21 at 3:45 p.m. She indicated she'd worked at the facility for a year and a half. Resident C just stayed in bed. She used to be able to transfer herself, but they were told not to transfer her anymore, and it had "been months" since she'd transferred her. The only time she was out of bed was for therapy, and to her knowledge, therapy was the only one to transfer her. She was unsure how they transferred her, and there were no mechanical lifts in the facility. She stated, "She's just in her room watching TV. She belongs in long term care. I thought she was supposed to move, but I don't know what happened with that." An interview was conducted with the Therapy Director on 11/10/21 at 3:53 p.m. She indicated Resident C hadn't been to therapy since 10/12/21, and that would have been the last time anyone from therapy transferred her from her bed. Resident C's POA (Power of			

	Attorney) situation was inconsistent. Her current POA had a power wheel chair and some furniture for her, but it never made it's way to the facility. An interview was conducted with the ED (Executive Director) on 11/10/21 at 12:58 p.m. She indicated they attempted to transfer her to a different facility, but she did not get accepted. She thought they were working on getting her into another one. An interview was conducted with the DON (Director of Nursing) on 11/10/21 at 3:17 p.m. She indicated she informed Resident C's court appointed POA that, "She needs to get out of here." They were in the process of sending paperwork to a potential facility, but there was some confusion with who would be taking over responsibility for overseeing her care. Resident C had been to the hospital twice in the last month or so, but she hadn't thought about having her go into long term care straight from the hospital. Her catheter should be changed monthly, but was unsure when it was last changed. There should be catheter care orders. If there were issues with her catheter, they sent her to the hospital. As far as appointments, they would set up transportation, if they knew she had one scheduled.			

	She was unaware of her needing shots for her knees or needing her second covid vaccination shot. Resident C received home health services, but she wasn't sure by which provider. She stated, "There's a huge breakdown in communication between home health and nursing," and there was no process in place to coordinate care between them. On 9/29/21 at 12:15 p.m., the DON provided the Residency Admission and Tenancy Requirements Policy, dated 2/2021, which read "...The community is licensed as a Residential Care Facility...As such, each resident of The Community must satisfy all of the following conditions for admission and residency: Each resident must be capable of self-preservation and independent daily living with assistance...The Community does not provide continuous intermediate or skilled nursing level of care and is not a 'comprehensive care facility'..." This Residential Tag relates to Complaint IN00365568.			
R 0090	Administration and Management - Deficiency 410 IAC 16.2-5-1.3(g)(1-6) (g) The administrator is responsible for the overall management of the	R 0090	R090 -**What corrective action(s) will be accomplished for those**	12/04/2021

	facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the:		**residents found to have been affected by the deficient practice?** Resident no longer lives at this community. -**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** No other resident was affected by this deficient practice -**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** DON/Designee will complete a full audit of resident’s charts on 11/12/21 to confirm that each service plan reflects the residents plan of care.	

	(A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request Based on observation, interview, and record review, the facility failed to assist a resident with obtaining injections for her knees and indwelling catheter changes for 1 of 2 residents reviewed for catheter care. (Resident C) Findings include: The clinical record for Resident C was reviewed on 11/10/21 at 10:47 a.m. The diagnoses included, but were not limited to, neuromuscular dysfunction of bladder and osteoarthritis. She was admitted to the facility on 7/7/21. The 5/24/21 Initial Assessment		-**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.** This process will be reviewed by DON/designee, IDT Team, and Administrator weekly for 8 weeks, monthly for 4 months and then as needed. At the monthly QA meetings, the results of the monitoring will be reviewed. Any patterns will be identified. If indicated, an Action Plan will be written by the QA Committee. Any Action Plan will be reviewed weekly by the Administrator until resolved. Any concerns will be addressed as discovered. -**By what date the systematic changes will be completed** December 04, 2021	

indicated "GL shots to knees Q [every] 3 months," and was episodically incontinent and used a catheter.

Resident C had no service plan.

The current physician's orders did not include any orders related to her catheter, including frequency of changing, nor did they include injections for her knees.

The June, 2021 physician's orders from Resident C's previous facility indicated for her Foley catheter to be changed monthly on the 15th of every month, and the 7/29/21 hospital notes also indicated her Foley catheter was to be changed once a month.

The 10/8/21, 3:48 p.m. nurse's note indicated 911 arrived and transported her to the hospital via gurney, and the 10/8/21, 9:03 p.m. nurse's note indicated her Foley catheter bag was changed at the emergency room.

An interview and observation was conducted with Resident C on 11/10/21 at 12:29 p.m. She was lying in bed. Her catheter bag was hanging along the side of her bed. She indicated her catheter needed changed, as it was last changed at the emergency room over a month ago, but should be changed every 30 days. It was supposed

	to be changed at a urology clinic, but she had an issue with transportation to get there, as she needed to be transported by stretcher. She rubbed her left knee and questioned when she would be getting the shots for her knees, as it had been 4 months since her last shots, and she had no transportation to get to an appointment for the shots. She stated, "They don't do anything about your appointments here." The 7/29/21 Physician Certification Statement for Ambulance Transport indicated Resident C was "not wheelchairable" due to postural instability. An interview was conducted with the ED (Executive Director) on 11/10/21 at 12:58. She indicated she was unaware of any appointments for Resident C. If she had one, perhaps she could recline or needed to go out via stretcher. An interview was conducted with the DON (Director of Nursing) on 11/10/21 at 2:37 p.m. She indicated she was unaware of any appointments needed for Resident C. If she was made aware of an appointment, they'd set up transportation. She was unaware of her needing shots in her knees every 3 months, as she did not work at the facility			

during the time of her preadmission evaluation.

The Non-Emergent Transportation Services Policy and Procedures was provided by the ED on 11/10/21 at 2:37 p.m. It read, "It is the policy of the facility to assist resident with non-emergent transportation needs. The facility staff will assist residents in locating and scheduling transportation for non-emergent needs, such as doctor appointments, shopping, or social visits."

The Catheter Care policy was provided by the ED on 11/10/21 at 2:37 p.m. It read, "It is the responsibility of the licensed nursing staff to change the collective device. Licensed nursing staff to coordinate transportation and office visit for change of catheter."

This Residential Tag relates to Complaint IN00365568.

Based on observation, interview, and record review, the facility failed to assist a resident with obtaining injections for her knees and indwelling catheter changes for 1 of 2 residents reviewed for catheter care. (Resident C)

Findings include:

The clinical record for Resident C was reviewed on 11/10/21 at 10:47 a.m. The diagnoses

included, but were not limited to, neuromuscular dysfunction of bladder and osteoarthritis. She was admitted to the facility on 7/7/21.

The 5/24/21 Initial Assessment indicated "GL shots to knees Q [every] 3 months," and was episodically incontinent and used a catheter.

Resident C had no service plan.

The current physician's orders did not include any orders related to her catheter, including frequency of changing, nor did they include injections for her knees.

The June, 2021 physician's orders from Resident C's previous facility indicated for her Foley catheter to be changed monthly on the 15th of every month, and the 7/29/21 hospital notes also indicated her Foley catheter was to be changed once a month.

The 10/8/21, 3:48 p.m. nurse's note indicated 911 arrived and transported her to the hospital via gurney, and the 10/8/21, 9:03 p.m. nurse's note indicated her Foley catheter bag was changed at the emergency room.

An interview and observation was conducted with Resident C on 11/10/21 at 12:29 p.m. She was lying in bed. Her catheter

	bag was hanging along the side of her bed. She indicated her catheter needed changed, as it was last changed at the emergency room over a month ago, but should be changed every 30 days. It was supposed to be changed at a urology clinic, but she had an issue with transportation to get there, as she needed to be transported by stretcher. She rubbed her left knee and questioned when she would be getting the shots for her knees, as it had been 4 months since her last shots, and she had no transportation to get to an appointment for the shots. She stated, "They don't do anything about your appointments here." The 7/29/21 Physician Certification Statement for Ambulance Transport indicated Resident C was "not wheelchairable" due to postural instability. An interview was conducted with the ED (Executive Director) on 11/10/21 at 12:58. She indicated she was unaware of any appointments for Resident C. If she had one, perhaps she could recline or needed to go out via stretcher. An interview was conducted with the DON (Director of Nursing) on 11/10/21 at 2:37 p.m. She indicated she was unaware of any appointments			

	needed for Resident C. If she was made aware of an appointment, they'd set up transportation. She was unaware of her needing shots in her knees every 3 months, as she did not work at the facility during the time of her preadmission evaluation. The Non-Emergent Transportation Services Policy and Procedures was provided by the ED on 11/10/21 at 2:37 p.m. It read, "It is the policy of the facility to assist resident with non-emergent transportation needs. The facility staff will assist residents in locating and scheduling transportation for non-emergent needs, such as doctor appointments, shopping, or social visits." The Catheter Care policy was provided by the ED on 11/10/21 at 2:37 p.m. It read, "It is the responsibility of the licensed nursing staff to change the collective device. Licensed nursing staff to coordinate transportation and office visit for change of catheter." This Residential Tag relates to Complaint IN00365568.			
R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (e) Following completion of an evaluation, the facility, using	R 0217	R217 -**What corrective action(s) will be**	12/04/2021

	appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.		**accomplished for those residents found to have been affected by the deficient practice?** Resident B, F, G service plan was reviewed and updated to reflect residents plan of care. Resident C no longer lives at this community. -**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** DON/Designee will complete a full audit of resident's charts on 11/12/21 to confirm that each service plan reflects the residents plan of care for appropriate placement. -**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?**	

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 observation, interview, and record review, the facility failed to administer residents' medications, ensure a resident's legs were cleansed and provide nursing care as ordered to 2 of 2 residents reviewed for catheter care and 1 of 3 residents reviewed for wounds. (Resident B, C, and E) Findings include: 1. The clinical record for Resident C was reviewed on 11/10/21 at 10:47 a.m. The diagnoses included, but were not limited to: type 2 diabetes, neuromuscular dysfunction of bladder, and osteoarthritis. She was admitted to the facility on 7/7/21. The 5/24/21 Initial Assessment indicated she needed assistance with bathing, dressing, meals/eating, laundry, housekeeping,	R 0241	R241 -**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident C no longer lives at this community Resident E service plane was reviewed and updated to reflect residents plan of care as ordered. Resident B has a wound Dr following him weekly and service plan has been updated to reflect his plan of care and orders -**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** All residents have the potential to be affected by this deficient practice. DON/Designee performed a chart and medication audit on	12/04/2021

walking/locomotion, standing, transfers, managing medications, transportation, shopping and finances. She had dentures, used a nebulizer, catheter, and wheel chair, had a history of falls, and received her first Covid vaccination dose. She required "GL shots to knees Q [every] 3 months."

The physician's orders for Resident C indicated a lidocaine 5% patch to be applied every morning and removed every evening, effective 10/11/21. There were no orders regarding her use of a catheter.

The October and November, 2021 MARs (medication administration records) indicated the lidocaine patch was not applied on the following dates: 10/14/21, 10/17/21, 10/18/21, 10/19/21, 10/22/21, 10/24/21, 10/25/21, 10/29/21, 11/2/21, 11/4/21, 11/6/21, 11/7/21, 11/9/21, and 11/10/21. The MARs indicated reasons for no application of the patch were that the patch was not available or was on order.

An interview and observation was conducted with Resident C on 11/10/21 at 12:29 p.m. She was lying in bed. Her catheter bag was hanging along the side of her bed. She indicated her catheter needed changed, as it had been over a month since it was last changed, and it was

11/12/21. Any findings were corrected, and all licensed nursing staff educated on medication administration policy by DON.

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

All licensed nursing staff educated on medication administration policy, Physician order policy, by DON on 11/12/2021. DON/Designee will perform medication administration and chart audits weekly for 6 months to ensure all orders are updated as ordered by the MD.

-**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.**

This process will be reviewed by DON/designee, IDT Team, and Administrator weekly for 8 weeks, monthly for 4 months and then

	supposed be changed every 30 days. The aides emptied the bag, but nursing did not change the catheter, regularly assess or clean the site, or change the bag. She only had 2 showers since admitted, because it was difficult to transfer her. The facility did not have a lift to transfer her, so they would put her on the side of the bed to transfer her, but it hurt to be transferred that way. If she had more help, she could get into the shower, but also needed a shower chair. Pain patches were ordered for her leg, but she never received them. She required shots to her knees every 3 months, but hadn't gotten them in 4 months. There was no one to get her to appointments from this facility, as she needed to go out via stretcher. She also never received her 2nd covid vaccination dose. She wanted to go to a different facility where she could get more assistance. She stated, "I'm not supposed to be here." An interview was conducted with the DON (Director of Nursing) on 11/10/21 at 3:17 p.m. She indicated there should be catheter care orders. Her catheter should be changed monthly, but was unsure when it was last changed. If there were issues with her catheter, they sent her to the hospital. As far as appointments, they would set		as needed. At the monthly QA meetings, the results of the monitoring will be reviewed. Any patterns will be identified. If indicated, an Action Plan will be written by the QA Committee. Any Action Plan will be reviewed weekly by the Administrator until resolved. Any concerns will be addressed as discovered. -**By what date the systematic changes will be completed** November 04, 2021	

up transportation, if they knew she had one scheduled. She was unaware of her needing shots for her knees or needing her second covid vaccination shot. Resident C received home health services, but she wasn't sure by which provider. She stated, "There's a huge breakdown in communication between home health and nursing," and there was no process in place to coordinate care between them.

2. The clinical record for Resident E was reviewed on 11/10/21 at 2:20 p.m. The diagnoses included, but were not limited to, recurrent urinary tract infections.

An observation of Resident E was made on 11/10/21 at 4:15 p.m. She was sitting in her wheel chair near the dining room. her catheter was draining reddish colored urine into the drainage bag on the side of her wheel chair.

The 10/9/21, 3:27 p.m. nurse's note indicated she continued with Keflex antibiotic for a diagnosis of urinary tract infection.

The 10/22/21 nurse's note indicated Resident E returned from the emergency room with new orders for Cipro every 12 hours for 14 days for a diagnosis of hemorrhagic

cystitis.

The 4/19/21 service plan indicated caregiver administration and/or observation of medications requiring judgment for necessity, dosage and/or effect.

The physician's orders did not reference her catheter use. They indicated Keflex 250 mg to be administered 3 times daily for 7 days, effective 10/8/21. They indicated for Cipro 500 mg to be administered every 12 hours for 14 days, effective 10/23/21.

The October, 2021 MAR (medication administration record) indicated Resident E did not receive 1 of her 3 daily doses of Keflex on 10/10/21, 10/12/21, 10/13/21, and 10/14/21, and did not receive 1 of her 2 daily doses of Cipro on 10/23/21 and 10/31/21.

An interview was conducted with the DON (Director of Nursing) on 11/10/21 at 3:33 p.m. She indicated Resident E should have catheter care orders. She had no way to input orders into the computer. Pharmacy input them. She needed to discuss how to enter treatment orders, such as catheter care, into the computer.

The Medication Oversight, Assistance and Administration policy was provided by the ED (Executive Director) on 11/10/21

at 2:37 p.m. It read, "Medication administration shall be provided by a licensed nurse....If medication administration is provided, the licensed nurse will document the administration including medication, dose, route, date, and time of administration on the Medication Assistance Record."

The Catheter Care policy was provided by the ED on 11/10/21 at 2:37 p.m. It read, "A. It is the responsibility of the licensed nursing staff to secure a physician's order for catheter. B. It is the responsibility of the nursing staff to cleanse and care for the catheter....D. It is the responsibility of the licensed nursing staff to change the collective device. Licensed nursing staff to coordinate transportation and office visit for change of catheter."

3. The clinical record for Resident B was reviewed on 11/10/21 at 11:00 a.m. The diagnosis for Resident B included, but was not limited to, cellulitis. The resident was admitted to the facility on 5/27/21.

An initial service plan dated 4/30/21 indicated Resident B needed supervision for bathing. The resident nor the family representative signed the initial service plan.

The initial care plan did not have a plan in place to address the care assistance needed for the resident's legs.

A Certified Nursing Assistant (CNA) task tab indicated as of 10/1/21, the CNA staff was to cleanse Resident B's legs and apply lotion every evening.

During a confidential interview on 11/10/21, she indicated Resident B had obtained an infection on his legs that had healed prior to admission to the facility. The resident was needing staff assistance with washing his lower legs, and the Director of Nursing (DON) indicated the care would be provided. Resident B had not received those services and now has wounds.

An interview was conducted with Resident B on 11/10/21 at 2:19 p.m. He indicated the wound doctor had been in this week. The doctor had washed his legs, applied a dressing to his wounds that was on his right leg, and wrapped both of his legs.

An interview was conducted with the DON on 11/10/21 2:10 p.m. She indicated the evening CNA staff was to cleanse and apply lotion to Resident B's legs every evening. The facility had been utilizing agency staff in the evenings. Resident B's clinical

record indicated the resident's legs had been cleansed and lotion applied on 10/11/21, 10/17/21 and 11/1/21. The staff should have been providing the care every evening.

An interview was conducted with Wound Nurse 10 on 11/10/21 at 3:01 p.m. She indicated she had seen and treated Resident B's legs this week. She had cleansed both legs with soap and water, applied collagen to the open areas and wrapped his legs with compression wraps.

This Residential Tag relates to Complaints IN00366365 and IN00365568.

Based on observation, interview, and record review, the facility failed to administer residents' medications, ensure a resident's legs were cleansed and provide nursing care as ordered to 2 of 2 residents reviewed for catheter care and 1 of 3 residents reviewed for wounds. (Resident B, C, and E)

Findings include:

1. The clinical record for Resident C was reviewed on 11/10/21 at 10:47 a.m. The diagnoses included, but were not limited to: type 2 diabetes, neuromuscular dysfunction of bladder, and osteoarthritis. She was admitted to the facility on 7/7/21.

The 5/24/21 Initial Assessment indicated she needed assistance with bathing, dressing, meals/eating, laundry, housekeeping, walking/locomotion, standing, transfers, managing medications, transportation, shopping and finances. She had dentures, used a nebulizer, catheter, and wheel chair, had a history of falls, and received her first Covid vaccination dose. She required "GL shots to knees Q [every] 3 months."

The physician's orders for Resident C indicated a lidocaine 5% patch to be applied every morning and removed every evening, effective 10/11/21. There were no orders regarding her use of a catheter.

The October and November, 2021 MARs (medication administration records) indicated the lidocaine patch was not applied on the following dates: 10/14/21, 10/17/21, 10/18/21, 10/19/21, 10/22/21, 10/24/21, 10/25/21, 10/29/21, 11/2/21, 11/4/21, 11/6/21,

11/7/21, 11/9/21, and 11/10/21. The MARs indicated reasons for no application of the patch were that the patch was not available or was on order.

An interview and observation was conducted with Resident C on 11/10/21 at 12:29 p.m. She was lying in bed. Her catheter bag was hanging along the side of her bed. She indicated her catheter needed changed, as it had been over a month since it was last changed, and it was supposed be changed every 30 days. The aides emptied the bag, but nursing did not change the catheter, regularly assess or clean the site, or change the bag. She only had 2 showers since admitted, because it was difficult to transfer her. The facility did not have a lift to transfer her, so they would put her on the side of the bed to transfer her, but it hurt to be transferred that way. If she had more help, she could get into the shower, but also needed a shower chair. Pain patches were ordered for her leg, but she never received them. She required shots to her knees every 3 months, but hadn't gotten them in 4 months. There was no one to get her to appointments from this facility, as she needed to go out via stretcher. She also never received her 2nd covid vaccination dose. She wanted to go to a different facility where

she could get more assistance. She stated, "I'm not supposed to be here."

An interview was conducted with the DON (Director of Nursing) on 11/10/21 at 3:17 p.m. She indicated there should be catheter care orders. Her catheter should be changed monthly, but was unsure when it was last changed. If there were issues with her catheter, they sent her to the hospital. As far as appointments, they would set up transportation, if they knew she had one scheduled. She was unaware of her needing shots for her knees or needing her second covid vaccination shot. Resident C received home health services, but she wasn't sure by which provider. She stated, "There's a huge breakdown in communication between home health and nursing," and there was no process in place to coordinate care between them.

2. The clinical record for Resident E was reviewed on 11/10/21 at 2:20 p.m. The diagnoses included, but were not limited to, recurrent urinary tract infections.

An observation of Resident E was made on 11/10/21 at 4:15 p.m. She was sitting in her wheel chair near the dining room. her catheter was draining reddish colored urine into the

drainage bag on the side of her wheel chair.

The 10/9/21, 3:27 p.m. nurse's note indicated she continued with Keflex antibiotic for a diagnosis of urinary tract infection.

The 10/22/21 nurse's note indicated Resident E returned from the emergency room with new orders for Cipro every 12 hours for 14 days for a diagnosis of hemorrhagic cystitis.

The 4/19/21 service plan indicated caregiver administration and/or observation of medications requiring judgment for necessity, dosage and/or effect.

The physician's orders did not reference her catheter use. They indicated Keflex 250 mg to be administered 3 times daily for 7 days, effective 10/8/21. They indicated for Cipro 500 mg to be administered every 12 hours for 14 days, effective 10/23/21.

The October, 2021 MAR (medication administration record) indicated Resident E did not receive 1 of her 3 daily doses of Keflex on 10/10/21, 10/12/21, 10/13/21, and 10/14/21, and did not receive 1 of her 2 daily doses of Cipro on 10/23/21 and 10/31/21.

An interview was conducted

with the DON (Director of Nursing) on 11/10/21 at 3:33 p.m. She indicated Resident E should have catheter care orders. She had no way to input orders into the computer. Pharmacy input them. She needed to discuss how to enter treatment orders, such as catheter care, into the computer.

The Medication Oversight, Assistance and Administration policy was provided by the ED (Executive Director) on 11/10/21 at 2:37 p.m. It read, "Medication administration shall be provided by a licensed nurse....If medication administration is provided, the licensed nurse will document the administration including medication, dose, route, date, and time of administration on the Medication Assistance Record."

The Catheter Care policy was provided by the ED on 11/10/21 at 2:37 p.m. It read, "A. It is the responsibility of the licensed nursing staff to secure a physician's order for catheter. B. It is the responsibility of the nursing staff to cleanse and care for the catheter....D. It is the responsibility of the licensed nursing staff to change the collective device. Licensed nursing staff to coordinate transportation and office visit for change of catheter."

3. The clinical record for

Resident B was reviewed on 11/10/21 at 11:00 a.m. The diagnosis for Resident B included, but was not limited to, cellulitis. The resident was admitted to the facility on 5/27/21.

An initial service plan dated 4/30/21 indicated Resident B needed supervision for bathing. The resident nor the family representative signed the initial service plan.

The initial care plan did not have a plan in place to address the care assistance needed for the resident's legs.

A Certified Nursing Assistant (CNA) task tab indicated as of 10/1/21, the CNA staff was to cleanse Resident B's legs and apply lotion every evening.

During a confidential interview on 11/10/21, she indicated Resident B had obtained an infection on his legs that had healed prior to admission to the facility. The resident was needing staff assistance with washing his lower legs, and the Director of Nursing (DON) indicated the care would be provided. Resident B had not received those services and now has wounds.

An interview was conducted with Resident B on 11/10/21 at 2:19 p.m. He indicated the wound doctor had been in this

week. The doctor had washed his legs, applied a dressing to his wounds that was on his right leg, and wrapped both of his legs.

An interview was conducted with the DON on 11/10/21 2:10 p.m. She indicated the evening CNA staff was to cleanse and apply lotion to Resident B's legs every evening. The facility had been utilizing agency staff in the evenings. Resident B's clinical record indicated the resident's legs had been cleansed and lotion applied on 10/11/21, 10/17/21 and 11/1/21. The staff should have been providing the care every evening.

An interview was conducted with Wound Nurse 10 on 11/10/21 at 3:01 p.m. She indicated she had seen and treated Resident B's legs this week. She had cleansed both legs with soap and water, applied collagen to the open areas and wrapped his legs with compression wraps.

This Residential Tag relates to Complaints IN00366365 and IN00365568.

Based on observation, interview, and record review, the facility failed to administer residents' medications, ensure a resident's legs were cleansed and provide nursing care as ordered to 2 of 2 residents

reviewed for catheter care and 1 of 3 residents reviewed for wounds. (Resident B, C, and E)

Findings include:

1. The clinical record for Resident C was reviewed on 11/10/21 at 10:47 a.m. The diagnoses included, but were not limited to: type 2 diabetes, neuromuscular dysfunction of bladder, and osteoarthritis. She was admitted to the facility on 7/7/21.

The 5/24/21 Initial Assessment indicated she needed assistance with bathing, dressing, meals/eating, laundry, housekeeping, walking/locomotion, standing, transfers, managing medications, transportation, shopping and finances. She had dentures, used a nebulizer, catheter, and wheel chair, had a history of falls, and received her first Covid vaccination dose. She required "GL shots to knees Q [every] 3 months."

The physician's orders for Resident C indicated a lidocaine 5% patch to be applied every morning and removed every evening, effective 10/11/21. There were no orders regarding her use of a catheter.

The October and November, 2021 MARs (medication administration records) indicated the lidocaine patch

was not applied on the following dates: 10/14/21, 10/17/21, 10/18/21, 10/19/21, 10/22/21, 10/24/21, 10/25/21, 10/29/21, 11/2/21, 11/4/21, 11/6/21, 11/7/21, 11/9/21, and 11/10/21. The MARs indicated reasons for no application of the patch were that the patch was not available or was on order.

An interview and observation was conducted with Resident C on 11/10/21 at 12:29 p.m. She was lying in bed. Her catheter bag was hanging along the side of her bed. She indicated her catheter needed changed, as it had been over a month since it was last changed, and it was supposed be changed every 30 days. The aides emptied the bag, but nursing did not change the catheter, regularly assess or clean the site, or change the bag. She only had 2 showers since admitted, because it was difficult to transfer her. The facility did not have a lift to transfer her, so they would put her on the side of the bed to transfer her, but it hurt to be transferred that way. If she had more help, she could get into the shower, but also needed a shower chair. Pain patches were ordered for her leg, but she never received them. She required shots to her knees every 3 months, but hadn't gotten them in 4 months. There was no one to get her to appointments from this facility,

as she needed to go out via stretcher. She also never received her 2nd covid vaccination dose. She wanted to go to a different facility where she could get more assistance. She stated, "I'm not supposed to be here."

An interview was conducted with the DON (Director of Nursing) on 11/10/21 at 3:17 p.m. She indicated there should be catheter care orders. Her catheter should be changed monthly, but was unsure when it was last changed. If there were issues with her catheter, they sent her to the hospital. As far as appointments, they would set up transportation, if they knew she had one scheduled. She was unaware of her needing shots for her knees or needing her second covid vaccination shot. Resident C received home health services, but she wasn't sure by which provider. She stated, "There's a huge breakdown in communication between home health and nursing," and there was no process in place to coordinate care between them.

2. The clinical record for Resident E was reviewed on 11/10/21 at 2:20 p.m. The diagnoses included, but were not limited to, recurrent urinary tract infections.

An observation of Resident E

was made on 11/10/21 at 4:15 p.m. She was sitting in her wheel chair near the dining room. her catheter was draining reddish colored urine into the drainage bag on the side of her wheel chair.

The 10/9/21, 3:27 p.m. nurse's note indicated she continued with Keflex antibiotic for a diagnosis of urinary tract infection.

The 10/22/21 nurse's note indicated Resident E returned from the emergency room with new orders for Cipro every 12 hours for 14 days for a diagnosis of hemorrhagic cystitis.

The 4/19/21 service plan indicated caregiver administration and/or observation of medications requiring judgment for necessity, dosage and/or effect.

The physician's orders did not reference her catheter use. They indicated Keflex 250 mg to be administered 3 times daily for 7 days, effective 10/8/21. They indicated for Cipro 500 mg to be administered every 12 hours for 14 days, effective 10/23/21.

The October, 2021 MAR (medication administration record) indicated Resident E did not receive 1 of her 3 daily doses of Keflex on 10/10/21, 10/12/21, 10/13/21, and

10/14/21, and did not receive 1 of her 2 daily doses of Cipro on 10/23/21 and 10/31/21.

An interview was conducted with the DON (Director of Nursing) on 11/10/21 at 3:33 p.m. She indicated Resident E should have catheter care orders. She had no way to input orders into the computer. Pharmacy input them. She needed to discuss how to enter treatment orders, such as catheter care, into the computer.

The Medication Oversight, Assistance and Administration policy was provided by the ED (Executive Director) on 11/10/21 at 2:37 p.m. It read, "Medication administration shall be provided by a licensed nurse....If medication administration is provided, the licensed nurse will document the administration including medication, dose, route, date, and time of administration on the Medication Assistance Record."

The Catheter Care policy was provided by the ED on 11/10/21 at 2:37 p.m. It read, "A. It is the responsibility of the licensed nursing staff to secure a physician's order for catheter. B. It is the responsibility of the nursing staff to cleanse and care for the catheter....D. It is the responsibility of the licensed nursing staff to change the collective device. Licensed

	nursing staff to coordinate transportation and office visit for change of catheter." 3. The clinical record for Resident B was reviewed on 11/10/21 at 11:00 a.m. The diagnosis for Resident B included, but was not limited to, cellulitis. The resident was admitted to the facility on 5/27/21. An initial service plan dated 4/30/21 indicated Resident B needed supervision for bathing. The resident nor the family representative signed the initial service plan. The initial care plan did not have a plan in place to address the care assistance needed for the resident's legs. A Certified Nursing Assistant (CNA) task tab indicated as of 10/1/21, the CNA staff was to cleanse Resident B's legs and apply lotion every evening.			

During a confidential interview on 11/10/21, she indicated Resident B had obtained an infection on his legs that had healed prior to admission to the facility. The resident was needing staff assistance with washing his lower legs, and the Director of Nursing (DON) indicated the care would be provided. Resident B had not received those services and now has wounds.

An interview was conducted with Resident B on 11/10/21 at 2:19 p.m. He indicated the wound doctor had been in this week. The doctor had washed his legs, applied a dressing to his wounds that was on his right leg, and wrapped both of his legs.

An interview was conducted with the DON on 11/10/21 2:10 p.m. She indicated the evening CNA staff was to cleanse and apply lotion to Resident B's legs every evening. The facility had been utilizing agency staff in the evenings. Resident B's clinical record indicated the resident's legs had been cleansed and lotion applied on 10/11/21, 10/17/21 and 11/1/21. The staff should have been providing the care every evening.

An interview was conducted with Wound Nurse 10 on 11/10/21 at 3:01 p.m. She indicated she had seen and

treated Resident B's legs this week. She had cleansed both legs with soap and water, applied collagen to the open areas and wrapped his legs with compression wraps.

This Residential Tag relates to Complaints IN00366365 and IN00365568.

Based on observation, interview, and record review, the facility failed to administer residents' medications, ensure a resident's legs were cleansed and provide nursing care as ordered to 2 of 2 residents reviewed for catheter care and 1 of 3 residents reviewed for wounds. (Resident B, C, and E)

Findings include:

1. The clinical record for Resident C was reviewed on 11/10/21 at 10:47 a.m. The diagnoses included, but were not limited to: type 2 diabetes, neuromuscular dysfunction of bladder, and osteoarthritis. She was admitted to the facility on 7/7/21.

The 5/24/21 Initial Assessment indicated she needed assistance with bathing, dressing, meals/eating, laundry, housekeeping, walking/locomotion, standing, transfers, managing medications, transportation, shopping and finances. She had dentures, used a nebulizer,

catheter, and wheel chair, had a history of falls, and received her first Covid vaccination dose. She required "GL shots to knees Q [every] 3 months."

The physician's orders for Resident C indicated a lidocaine 5% patch to be applied every morning and removed every evening, effective 10/11/21. There were no orders regarding her use of a catheter.

The October and November, 2021 MARs (medication administration records) indicated the lidocaine patch was not applied on the following dates: 10/14/21, 10/17/21, 10/18/21, 10/19/21, 10/22/21, 10/24/21, 10/25/21, 10/29/21, 11/2/21, 11/4/21, 11/6/21, 11/7/21, 11/9/21, and 11/10/21. The MARs indicated reasons for no application of the patch were that the patch was not available or was on order.

An interview and observation was conducted with Resident C on 11/10/21 at 12:29 p.m. She was lying in bed. Her catheter bag was hanging along the side of her bed. She indicated her catheter needed changed, as it had been over a month since it was last changed, and it was supposed be changed every 30 days. The aides emptied the bag, but nursing did not change the catheter, regularly assess or clean the site, or change the

bag. She only had 2 showers since admitted, because it was difficult to transfer her. The facility did not have a lift to transfer her, so they would put her on the side of the bed to transfer her, but it hurt to be transferred that way. If she had more help, she could get into the shower, but also needed a shower chair. Pain patches were ordered for her leg, but she never received them. She required shots to her knees every 3 months, but hadn't gotten them in 4 months. There was no one to get her to appointments from this facility, as she needed to go out via stretcher. She also never received her 2nd covid vaccination dose. She wanted to go to a different facility where she could get more assistance. She stated, "I'm not supposed to be here."

An interview was conducted with the DON (Director of Nursing) on 11/10/21 at 3:17 p.m. She indicated there should be catheter care orders. Her catheter should be changed monthly, but was unsure when it was last changed. If there were issues with her catheter, they sent her to the hospital. As far as appointments, they would set up transportation, if they knew she had one scheduled. She was unaware of her needing shots for her knees or needing her second covid vaccination

shot. Resident C received home health services, but she wasn't sure by which provider. She stated, "There's a huge breakdown in communication between home health and nursing," and there was no process in place to coordinate care between them.

2. The clinical record for Resident E was reviewed on 11/10/21 at 2:20 p.m. The diagnoses included, but were not limited to, recurrent urinary tract infections.

An observation of Resident E was made on 11/10/21 at 4:15 p.m. She was sitting in her wheel chair near the dining room. her catheter was draining reddish colored urine into the drainage bag on the side of her wheel chair.

The 10/9/21, 3:27 p.m. nurse's note indicated she continued with Keflex antibiotic for a diagnosis of urinary tract infection.

The 10/22/21 nurse's note indicated Resident E returned from the emergency room with new orders for Cipro every 12 hours for 14 days for a diagnosis of hemorrhagic cystitis.

The 4/19/21 service plan indicated caregiver administration and/or observation of medications

requiring judgment for necessity, dosage and/or effect.

The physician's orders did not reference her catheter use. They indicated Keflex 250 mg to be administered 3 times daily for 7 days, effective 10/8/21. They indicated for Cipro 500 mg to be administered every 12 hours for 14 days, effective 10/23/21.

The October, 2021 MAR (medication administration record) indicated Resident E did not receive 1 of her 3 daily doses of Keflex on 10/10/21, 10/12/21, 10/13/21, and 10/14/21, and did not receive 1 of her 2 daily doses of Cipro on 10/23/21 and 10/31/21.

An interview was conducted with the DON (Director of Nursing) on 11/10/21 at 3:33 p.m. She indicated Resident E should have catheter care orders. She had no way to input orders into the computer. Pharmacy input them. She needed to discuss how to enter treatment orders, such as catheter care, into the computer.

The Medication Oversight, Assistance and Administration policy was provided by the ED (Executive Director) on 11/10/21 at 2:37 p.m. It read, "Medication administration shall be provided by a licensed nurse....If medication administration is provided, the licensed nurse will

document the administration including medication, dose, route, date, and time of administration on the Medication Assistance Record."

The Catheter Care policy was provided by the ED on 11/10/21 at 2:37 p.m. It read, "A. It is the responsibility of the licensed nursing staff to secure a physician's order for catheter. B. It is the responsibility of the nursing staff to cleanse and care for the catheter....D. It is the responsibility of the licensed nursing staff to change the collective device. Licensed nursing staff to coordinate transportation and office visit for change of catheter."

3. The clinical record for Resident B was reviewed on 11/10/21 at 11:00 a.m. The diagnosis for Resident B included, but was not limited to, cellulitis. The resident was admitted to the facility on 5/27/21.

An initial service plan dated 4/30/21 indicated Resident B needed supervision for bathing. The resident nor the family representative signed the initial service plan.

The initial care plan did not have a plan in place to address the care assistance needed for the resident's legs.

A Certified Nursing Assistant

	(CNA) task tab indicated as of 10/1/21, the CNA staff was to cleanse Resident B's legs and apply lotion every evening. During a confidential interview on 11/10/21, she indicated Resident B had obtained an infection on his legs that had healed prior to admission to the facility. The resident was needing staff assistance with washing his lower legs, and the Director of Nursing (DON) indicated the care would be provided. Resident B had not received those services and now has wounds. An interview was conducted with Resident B on 11/10/21 at 2:19 p.m. He indicated the wound doctor had been in this week. The doctor had washed his legs, applied a dressing to his wounds that was on his right leg, and wrapped both of his legs.			

	An interview was conducted with the DON on 11/10/21 2:10 p.m. She indicated the evening CNA staff was to cleanse and apply lotion to Resident B's legs every evening. The facility had been utilizing agency staff in the evenings. Resident B's clinical record indicated the resident's legs had been cleansed and lotion applied on 10/11/21, 10/17/21 and 11/1/21. The staff should have been providing the care every evening. An interview was conducted with Wound Nurse 10 on 11/10/21 at 3:01 p.m. She indicated she had seen and treated Resident B's legs this week. She had cleansed both legs with soap and water, applied collagen to the open areas and wrapped his legs with compression wraps. This Residential Tag relates to Complaints IN00366365 and IN00365568.			

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