STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	12/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE MEADOWS SENIOR ASSISTED LIVING	11570 E 126TH STREET, FISHERS, , 46037

(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 Complaint IN00367739 and IN00368456. Complaint IN00367739-Substantiated. State deficiencies related to the allegations are cited at R240, R268, and R269. Complaint IN00368456-Substantiated. State deficiencies related to the allegations are cited at R240, R268, and R269. Survey date: December 6-7, 2021 Facility number: 014910 Residential Census: 108 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on December 10, 2021	R 0000	Please accept the attached plan of correction as credible allegation of compliance to the deficiencies cited during the Investigation of Complaint conducted on December 6-7, 2021. Hopefully, you will find the remedies are sufficient, thoroughly explained, and able to provide a clear picture of how we corrected the concern. I would like to formally request your consideration for granting this community paper 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 observation and record review, the facility failed to administer medications timely for 4 of 4 residents (Residents J, K, L and M) and failed to appropriately document the administration of a pain medication in the medication administration record (MAR) for 1 of 4 residents (Resident M) reviewed for medication administration. Findings include: 1. a. An observation was made on 12/7/21 at 10:38 a.m. of QMA (Qualified Medication Assistant) 3. QMA 3 administered Resident J her medications. The medications administered were ferrex (iron), Lasix (diuretic), paroxetine (depression medication), vitamin B, spironolactone (diuretic) and lactulose (laxative and ammonia reducer). A review of Resident J's December MAR conducted on 12/7/21 at 10:38 a.m. indicated, the ferrex, Lasix, paroxetine, vitamin B, spironolactone and	R 0240	Upon the discovery of this allegation of deficiency, Lake Meadows immediately began an investigation. Upon investigation it was discovered that all Nursing staff that handle medications should be re-educated on medication policy and procedures, including regulation regarding preparation, administration, and documentation of medication administration.random medication administration observation with staff for compliance with medication administration guidelines as follows: 3 times weekly for one month; 2 times weekly for two months and weekly thereafter. Any deficiencies found in the audits will be corrected at the time discovered and retraining provided, as appropriate. Findings will be reported to the QAPI Committee.	01/25/2022

lactulose were to be administered at 8 a.m. Resident J did not receive her medications until 10:38 a.m.

Resident J's Level of Care completed on 11/1/21 indicated, Resident J was oriented to person, place, and time and makes safe decisions in familiar settings.

An interview with Resident J indicated, "I don't always get my medicines and I never get the lactulose".

b. An observation was made on 12/7/21 at 10:49 a.m. of QMA 3. QMA 3 administered Resident K her medications. The medications administered were calcium, diclofenac (anti-inflammatory pain medication), metoprolol (blood pressure medication), mybertiq (overactive bladder medication), and vitamin D3.

A review of Resident K's December MAR was conducted on 12/7/21 at 10:49 a.m. indicated, the calcium, diclofenac, metoprolol, mybertiq, and vitamin D3 were to be administered in the a.m. with a range time of 8 a.m. to 10 a.m. Resident K's medications were not administered until 10:49 a.m.

c. An observation was made on 12/7/21 at 10:56 a.m. of QMA 3. QMA 3 administered Resident

	L's eye medications. The medications administered were combigan (high eye pressure medication) and dorzalamide (glaucoma medication). A review of Resident L's December MAR was conducted on 12/7/21 at 10:56 a.m. It indicated, the combigan and dorzalamide eye drops were to administered at 8 a.m. The medications did not get administered until 10:56 a.m. d. An interview was conducted on 12/6/21 at 4:33 p.m. with the Assisted Living State Ombudsman. She indicated, she was in the facility on 12/3/21 and in Resident M's room when the nurse on duty came to administer Resident M's morning medications. The Ombudsman indicated, Resident M had not received her morning medications until 11:58 a.m. An interview with Resident M was conducted on 12/6/21 at 1:27 p.m. She indicated, the facility is always getting her medications wrong, "They give me too many or are missing pills, or ones that aren't yours". She further stated, on 12/3/21, she had received her thyroid medication early in the morning but the remainder of her morning medications did not arrive until after 11:30 a.m. when the Ombudsman was			

present.

2. The clinical record for Resident M was reviewed on 12/7/21 at 12:17 p.m.

A physician's order dated 5/6/21 for Tramadol (pain medication) indicated, give one 100 mg (milligrams) tablet every 6 hours as needed for pain.

A copy of Resident M's Controlled Drug use sheet was provided on 12/7/21 at 12:29 p.m. by DON (Director of Nursing). It indicated, Resident M was administered Tramadol on the following dates and times:

11/29/21 at 6 a.m.

11/29/21 at 8 p.m.

12/4/21 at 9 a.m.

12/5/21 at 4 a.m.

12/5/21 at 10 a.m.

12/5/21 at 8 p.m.

12/6/21 at 4 a.m.

12/6/21 at 2 p.m.

Resident M's November and December MAR's were provided on 12/7/21 at 2:30 p.m. by DON. The November MAR did not indicate any administrations of Tramadol on 11/29/21. The December MAR did not indicate

	administrations of Tramadol for the following dates and times: 12/4/21 at 9 a.m. 12/5/21 at 4 a.m. 12/5/21 at 10 a.m. 12/5/21 at 8 p.m. 12/6/21 at 4 a.m. 12/6/21 at 2 p.m. An interview with DON was conducted on 12/7/21 at 12:29 p.m. indicated, nursing is to document all administrations of medications on the MAR. This state finding relates to complaints IN00368456 and IN00367739. Based on observation and record review, the facility failed to administer medications timely for 4 of 4 residents (Residents J, K, L and M) and failed to appropriately document the administration of a pain medication in the medication administration record (MAR) for 1 of 4 residents (Resident M) reviewed for medication administration. Findings include: 1. a. An observation was made on 12/7/21 at 10:38 a.m. of QMA (Qualified Medication Assistant) 3. QMA 3			

	administered Resident J her medications. The medications administered were ferrex (iron), Lasix (diuretic), paroxetine (depression medication), vitamin B, spironolactone (diuretic) and lactulose (laxative and ammonia reducer). A review of Resident J's December MAR conducted on 12/7/21 at 10:38 a.m. indicated, the ferrex, Lasix, paroxetine, vitamin B, spironolactone and lactulose were to be administered at 8 a.m. Resident J did not receive her medications until 10:38 a.m. Resident J's Level of Care completed on 11/1/21 indicated, Resident J was oriented to person, place, and time and makes safe decisions in familiar settings. An interview with Resident J indicated, "I don't always get my medicines and I never get the lactulose". b. An observation was made on 12/7/21 at 10:49 a.m. of QMA 3. QMA 3 administered Resident K her medications. The medications administered were calcium, diclofenac (anti-inflammatory pain medication), metoprolol (blood pressure medication), mybertiq (overactive bladder medication), and vitamin D3. A review of Resident K's			

	December MAR was conducted on 12/7/21 at 10:49 a.m. indicated, the calcium, diclofenac, metoprolol, mybertiq, and vitamin D3 were to be administered in the a.m. with a range time of 8 a.m. to 10 a.m. Resident K's medications were not administered until 10:49 a.m. c. An observation was made on 12/7/21 at 10:56 a.m. of QMA 3. QMA 3 administered Resident L's eye medications. The medications administered were combigan (high eye pressure medication) and dorzalamide (glaucoma medication). A review of Resident L's December MAR was conducted on 12/7/21 at 10:56 a.m. It indicated, the combigan and dorzalamide eye drops were to administered at 8 a.m. The medications did not get administered until 10:56 a.m. d. An interview was conducted on 12/6/21 at 4:33 p.m. with the Assisted Living State Ombudsman. She indicated, she was in the facility on 12/3/21 and in Resident M's room when the nurse on duty came to administer Resident M's morning medications. The Ombudsman indicated, Resident M had not received her morning medications until 11:58 a.m.			

	An interview with Resident M was conducted on 12/6/21 at 1:27 p.m. She indicated, the facility is always getting her medications wrong, "They give me too many or are missing pills, or ones that aren't yours". She further stated, on 12/3/21, she had received her thyroid medication early in the morning but the remainder of her morning medications did not arrive until after 11:30 a.m. when the Ombudsman was present. 2. The clinical record for Resident M was reviewed on 12/7/21 at 12:17 p.m. A physician's order dated 5/6/21 for Tramadol (pain medication) indicated, give one 100 mg (milligrams) tablet every 6 hours as needed for pain. A copy of Resident M's Controlled Drug use sheet was provided on 12/7/21 at 12:29 p.m. by DON (Director of Nursing). It indicated, Resident M was administered Tramadol on the following dates and times: 11/29/21 at 6 a.m. 11/29/21 at 8 p.m. 12/4/21 at 9 a.m. 12/5/21 at 4 a.m.			

	12/5/21 at 10 a.m. 12/5/21 at 8 p.m. 12/6/21 at 4 a.m. 12/6/21 at 2 p.m. Resident M's November and December MAR's were provided on 12/7/21 at 2:30 p.m. by DON. The November MAR did not indicate any administrations of Tramadol on 11/29/21. The December MAR did not indicate administrations of Tramadol for the following dates and times: 12/4/21 at 9 a.m. 12/5/21 at 4 a.m. 12/5/21 at 10 a.m. 12/5/21 at 8 p.m. 12/6/21 at 4 a.m. 12/6/21 at 2 p.m. An interview with DON was conducted on 12/7/21 at 12:29 p.m. indicated, nursing is to document all administrations of medications on the MAR. This state finding relates to complaints IN00368456 and IN00367739.			
R 0268	Food and Nutritional Services - Deficiency	R 0268	It is Lake Meadows intention to provide, arrange, or make available three well-planned	01/25/2022

	410 IAC 16.2-5-5.1(a) (a) The facility shall provide, arrange, or make available three (3) well-planned meals a day, seven (7) days a week that provide a balanced distribution of the daily nutritional requirements. Based on interview and record review, the facility failed to provide and make available three well planned meals a day, 7 days a week that provided a balanced distribution of the daily nutritional requirements by not following the preplanned and registered dietician approved menu for the residents that reside at the facility. (108 residents) Findings include: An interview was conducted on 12/6/21 at 11:40 a.m. with Resident B. Resident B indicated, the facility is not serving 3 warm meals a day. She stated, "It's not breakfast" when all they set out rolls, cold cereal and instant oatmeal but don't offer bacon, sausage, eggs or biscuits and gravy. They used to have a cooked, warm breakfast but that changed a while ago. An interview was conducted on 12/6/21 at 12:11 p.m. with Resident C. Resident C indicated, the facility used to serve a warm breakfast, but not anymore. The facility now		meals a day, seven days a week that provide a balanced distribution of the daily nutritional requirements. The alleged deficiency has the potential to impact all residents. The alleged deficiency was corrected upon identification. The community resumed dining room service for all meals. The community contracts with a dietitian service so that all menus are reviewed and approved by a registered dietitian prior to distribution to the community. To ensure the alleged deficiency does not reoccur, all dietary staff will be re-educated on the menu system and pertinent dietary policies and procedures by 1/25/2022. The Executive Director, or designee, will review dietary meal schedules weekly for 1 month and monthly thereafter. Any concerns will be documented and corrected. All findings will be reported to the QAPI Committee.	

	serves a continental type breakfast most of the time during the week where they serve "bagels and English muffins and put the toaster out in the bistro area". Resident C stated, a different cook works on the weekends and they try to make sure the residents get a warm breakfast then but that does not happen usually on the weekdays. She indicated, this change to the breakfast menu changed a couple months ago. An interview was conducted on 12/7/21 at 8:40 a.m. with Resident D. Resident D indicated, the facility just started serving a warm, cooked breakfast during the weekdays that very morning. She indicated, usually the breakfast meal was served in the bistro area of the facility and only had cold items to choose from and some residents would take it to their rooms to eat because the bistro area was smaller than the dining room. A copy of the facility's menu's from November 2021 to present was provided by the AED (Assistant Executive Director) on 12/7/21 at 10:12 a.m. The provided menus were prepared by a Dietary Consultant company the facility used to ensure residents receive 3 nutritionally balanced meals each day. The menus did not reflect a continental type			

	breakfast, but rather items, including but not limited to: quiche, pancakes, eggs cooked to order; banana french toast, omelets, breakfast meat of choice, etc. The breakfast menu provided versus the breakfast served were not the same.			

	An interview was conducted on 12/7/21 at 9:19 a.m. with MS (Menu Specialist). MS indicated, what there company provides is a web based program in which they create menus for the community which are nutritionally balanced. If a community wished to change the menu, then the community needed to input the changes into the program to ensure the nutritional content is met based on the changes. The changes then would be authorized by the registered dietician and observed by a signature on the bottom of the menu. MS stated, if the changes were not placed into the program, then the nutritional information would be incorrect and may lead to deficits in nutrition. MS stated, it is the community's responsibility to ensure someone is trained on using the program they provide and the person should be the dietary manager. MS indicated, they do not provide any supervisory services to ensure the community was following the menus. "It was up to the community and they are supposed to follow the menus". An interview was conducted with AED on 12/7/21 at 9:33 a.m. AED indicated, the facility changed the breakfast menu to a continental type breakfast on October 4, 2021 due to a staffing issue. The facility did not have a morning cook nor			

	morning dietary assistants to provide a breakfast service. AED indicated, when they did have staff, they would serve a cooked, warm breakfast. AED indicated, with a few exceptions, the breakfast menu had not been followed since October and this was approved by the Regional Director of Operations (RDO) and Regional Dietary Manager (RDM). The RDM was filling in at the facility as their dietary manager since they did not have one. An interview with RDM was conducted on 12/7/21 at 10:02 a.m. RDM indicated, they (RDO and RDM) decided to go to a continental type breakfast because they had looked at the resident's lease agreements and those agreements indicated, the facility only needed to provide 2 meals a day (lunch and dinner) so they believed a continental breakfast was sufficient. RDM stated, he did not place the changes to the breakfast menu into the dietary program to ensure the residents were receiving 3 nutritionally balanced meals per day. This state finding relates to complaints IN00368456 and IN00367739. Based on interview and record review, the facility failed to provide and make available three well planned meals a day,			

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R 0269	Food and Nutritional Services - Noncompliance 410 IAC 16.2-5-5.1(b) (b) The menu or substitutions, or both, for all meals shall be	R 0269	It is Lake Meadows intention to ensure all menus and substitutions are approved by a registered dietician. The alleged deficiency has the potential to impact all residents. The alleged	01/25/2022

	approved by a registered dietician. Based on interview and record review, the facility failed to ensure menu substitutions were approved by a registered dietician for the residents that reside at the facility. (108 residents) Findings include: An interview was conducted on 12/6/21 at 11:40 a.m. with Resident B. Resident B indicated, the facility is not serving 3 warm meals a day. She stated, "It's not breakfast" when all they set out rolls, cold cereal and instant oatmeal but don't offer bacon, sausage, eggs or biscuits and gravy. They used to have a cooked, warm breakfast but that changed a while ago. An interview was conducted on 12/6/21 at 12:11 p.m. with Resident C. Resident C indicated, the facility used to serve a warm breakfast, but not anymore. The facility now serves a continental type breakfast most of the time during the week where they serve "bagels and English muffins and put the toaster out in the bistro area". Resident C stated, a different cook works on the weekends and they try to make sure the residents get a warm breakfast then but that does not happen usually on the		deficiency was corrected upon identification. The community resumed dining room service for all meals. The community contracts with a dietitian service so that all menus are reviewed and approved by a registered dietitian prior to distribution to the community. To ensure the alleged deficiency does not reoccur, all dietary staff will be re-educated on the menu system and pertinent dietary policies and procedures by 1/25/22. The Executive Director, or designee, will review dietary meal schedules and alternative menus weekly for 1 month and monthly thereafter. Any concerns will be documented and corrected. All findings will be reported to the QAPI Committee.	

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	An interview with RDM was conducted on 12/7/21 at 10:02 a.m. RDM indicated, he did not place the changes to the breakfast menu into the dietary program to ensure the residents were receiving 3 nutritionally balanced meals per day. By not placing the changes into the dietary program, a registered dietician was not consulted regarding the changes to the menu and could not ensure the menu was nutritionally balanced for the residents. This state finding relates to complaints IN00368456 and IN00367739. Based on interview and record review, the facility failed to ensure menu substitutions were approved by a registered dietician for the residents that reside at the facility. (108 residents) Findings include: An interview was conducted on 12/6/21 at 11:40 a.m. with Resident B. Resident B indicated, the facility is not serving 3 warm meals a day. She stated, "It's not breakfast" when all they set out rolls, cold cereal and instant oatmeal but don't offer bacon, sausage, eggs or biscuits and gravy. They used to have a cooked, warm breakfast but that changed a while ago.			

	An interview was conducted on 12/6/21 at 12:11 p.m. with Resident C. Resident C indicated, the facility used to serve a warm breakfast, but not anymore. The facility now serves a continental type breakfast most of the time during the week where they serve "bagels and English muffins and put the toaster out in the bistro area". Resident C stated, a different cook works on the weekends and they try to make sure the residents get a warm breakfast then but that does not happen usually on the weekdays. She indicated, this change to the breakfast menu changed a couple months ago. An interview was conducted on 12/7/21 at 8:40 a.m. with Resident D. Resident D indicated, usually the breakfast meal was served in the bistro area of the facility and only had cold items to choose from. A copy of the facility's menu's from November 2021 to present was provided by the AED (Assistant Executive Director) on 12/7/21 at 10:12 a.m. The provided menus were prepared by a Dietary Consultant company the facility used to ensure residents receive 3 nutritionally balanced meals each day. The menus did not reflect a continental type breakfast, but rather items, including but not limited to:			

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R 0407	Infection Control - Noncompliance 410 IAC 16.2-5-12(b)(1-4) (b) The facility must establish an infection control program that	R 0407	It is Lake Meadows intention to provide every resident with a safe, sanitary, and comfortable environment and help prevent the development and	01/25/2022

includes the following:

(1) A system that enables the facility to analyze patterns of known infectious symptoms.

(2) Provides orientation and in-service education on infection prevention and control, including universal precautions.

(3) Offering health information to residents, including, but not limited to, infection transmission and immunizations.

(4) Reporting communicable disease to public health authorities.

Based on observations and interviews, the facility failed maintain an infection control practice to properly prevent and/or contain COVID-19 and provide a sanitary environment by not wearing a mask and/or faceshield properly when within 6 feet of residents during two random observations (Residents B, E, F, and G), not utilizing the proper type of mask in the kitchen, residents' trash bags in hallways, and not disposing of used PPE (personal protective equipment) properly.

Findings include:

1. a. A random observation of Activity Director (AD) was made on 12/6/21 at 11:08 a.m. AD was in the activity room and sitting at a table with 3 residents (Resident B, E, and F). The activity going on at the time was

transmission of diseases and infection.Upon the discovery of this allegation of noncompliance, Lake Meadows immediately began an investigation. Upon investigation it was discovered that all staff should be re-educated on infection control guidelines including trash removal, and community policy and procedures for COVID -19 to include proper use, donning and doffing, and disposal of PPE.

To ensure deficiency does not reoccur, re-education to the Leadership team has been conducted by the Director of Clinical Services and the Director of Regional Operations. The leadership team all staff will complete re-education on Infection Control Guidelines and Community policy and procedures for COVID-19 no later than 1/25/2022. Education will be conducted in theform of verbal and written in-servicing.

bingo and AD was calling out letters and numbers. AD's faceshield was pushed up so that it was positioned like a visor and not covering her face. Her mask was below her nose. AD was sitting less than 6 feet from Residents B, E, and F. Residents B, E, and F were not wearing face masks.

b. A random observation of OT (Occupational Therapist) was made on 12/7/21 at 9:29 a.m. OT was seated directly across from Resident G as she was performing her therapy. OT's faceshield was pushed up so that it was positioned like a visor and was not covering his face. His mask was below his nose. OT was less than 6 feet from Resident G at the time.

An interview with AED (Assistant Executive Director) was conducted on 12/6/21 at 10:33 a.m. AED indicated, the staff was to wear a faceshield (eye protection) when within 6 feet of a resident and when providing care.

2. A random observation of KC (kitchen cook) 7 was made on 12/7/21 at 8:53 a.m. While in the kitchen, KC 7 was observed with a neck "gaitor" (sic, an article of clothing worn about the neck; Often a closed tube of fabric) pulled up and covering his nose and mouth.

The State of Indiana's Department of Health's COVID-19 Infection Control Guidance, last updated 11/22/21, indicated, "Masks (covering mouth and nose) and Eye Protection: Direct and indirect care HCP[sic, healthcare professionals] should wear a medical procedure mask for the duration of their shifts. N95 respirator mask should be worn in COVID-19 units and with any resident who is symptomatic or in TBP[sic, transmission based-precautions] (red or yellow zone) awaiting testing. While supplies are limited, masks should be conserved and only a single mask should be worn by HCP each shift. N95 mask may only be removed (doffed) five times before it should be discarded. Masks should be changed when visibly soiled or wet. When possible, by supply and lower transmission in the facility, mask use can return to conventional usage and NIOSH-approved N95 respirators."

3. Multiple random observations were made between 12/6/21 and 12/7/21 of residents' trash bags out in the hallways throughout the facility. The trash bags were observed on the ground, in the hallways at multiple times throughout day. While walking down the 1st and 2nd floor hallways on 12/7/21 at 11:06 a.m., 6 bags of trash were

observed sitting on the ground, outside of 6 resident rooms. The same bags of trash were later observed at 2:14 p.m. the same day.

An interview with AED (Assistant Executive Director) was conducted on 12/7/21 at 3:26 p.m. AED indicated, the trash pick up procedure in place was the CNAs (Certified Nursing Assistants) are supposed to pick up the trash bags outside the resident rooms once per shift during days and evenings. She indicated, the residents however place their trash outside of their doors at all times of the day and it is the responsibility of the staff to pick it up when they see it. AED explained, the facility used to have 4 trash rooms throughout the facility so staff could pick up trash bags then place them in a trash room, but the trash rooms have since been discontinued. She indicated, some of the residents used to take their trash to the trash room instead of leaving it in the hallways, but that is not an option at this time.

4. A random observation of trash pickup was observed on 12/7/21 at 2:15 p.m. Two CNAs were observed emptying Resident H's trash receptacle, which was located outside of Resident H's room. Resident H's uncovered receptacle had been observed in the hallway on

12/7/21 at 11:06 a.m. When the CNA dumped the trash out of the small, black receptacle into the large trash can, used PPE gowns, masks, and gloves freely fell out. The used PPE was not previously bagged and left open to air in the hallway.

Resident H had been in droplet isolation precautions related to a possible exposure to COVID-19. Resident H was placed on isolation on 12/2/21.

An interview with AED conducted on 12/7/21 at 3:26 p.m. indicated, used PPE should be disposed of inside the resident's room and handled appropriately. A trash can containing used PPE should not be in the hallway.

Based on observations and interviews, the facility failed maintain an infection control practice to properly prevent and/or contain COVID-19 and provide a sanitary environment by not wearing a mask and/or faceshield properly when within 6 feet of residents during two random observations (Residents B, E, F, and G), not utilizing the proper type of mask in the kitchen, residents' trash bags in hallways, and not disposing of used PPE (personal protective equipment) properly.

Findings include:

1. a. A random observation of

Activity Director (AD) was made on 12/6/21 at 11:08 a.m. AD was in the activity room and sitting at a table with 3 residents (Resident B, E, and F). The activity going on at the time was bingo and AD was calling out letters and numbers. AD's faceshield was pushed up so that it was positioned like a visor and not covering her face. Her mask was below her nose. AD was sitting less than 6 feet from Residents B, E, and F. Residents B, E, and F were not wearing face masks.

b. A random observation of OT (Occupational Therapist) was made on 12/7/21 at 9:29 a.m. OT was seated directly across from Resident G as she was performing her therapy. OT's faceshield was pushed up so that it was positioned like a visor and was not covering his face. His mask was below his nose. OT was less than 6 feet from Resident G at the time.

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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