STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K076	A. BUILDING B. WING	10/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heaven Sent Home Health Care Llc	716 SOUTH PARK AVENUE, ALEXANDRIA, IN, 46001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS - REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 484.102 Survey Dates: October 22, 23, 24, 25, 28, 2024 Active Census: 28 At this Emergency Preparedness survey, Heaven Sent Home Health Care, LLC was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 484.102	E0000		
G0000	INITIAL COMMENTS This visit was for a Federal Recertification and State Re-Licensure survey of a Home Health Provider.	G0000	Heaven Sent Home Health Care is submitting the followingPlan of Correction in response to the CMS-2567 issued by ISDH and/or CMS as itis required to do by applicable state and	

	Survey Dates: October 22, 23, 24, 25, 28, 2024 12 Month Unduplicated Skilled Admissions: 2 This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Refer to State Form for additional State Findings. QR 11/6/24 A2		federal regulations. The submissionof this Plan of Correction is not intended as an admission, does not constitutean admission by and should not be construed as an admission by Heaven Sent HomeHealth Care that the findings and allegations contained herein areaccurate and true representations of the quality of care and services providedto patients of the Agency. Heaven Sent Home Health Care desires thisPlan of Correction to be considered our Allegation of Compliance."	
G0514	RN performs assessment 484.55(a)(1) A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status. The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician or allowed practitioner - ordered start of care date. Based on record review and interview, the home health agency failed to conduct an initial assessment to determine the patient's immediate care and support needs within 48 hours of	G0514	**G0514:** All clinical staff casewere educated/in-serviced on policy 2.09 on 11/5/2024. All records cited in the survey have been corrected withMD/practitioner notification of stated deficiency as of 11/5/24. All of theclinical records were reviewed and if needed, verbal notification toMD/practitioner was completed for compliance as of 11/5/2024. The Administrator and/or DON	2024-11-05

	referral for 1 of 4 active records receiving HHA services only (Patient #6). Findings include: 1. The agency policy "Referrals and Acceptance of Client", last updated July 2024, indicated the assigned clinical staff member will obtain a physician order to assess individual for home care services and complete this assessment within 48 hours of referral. 2. Patient #6's clinical record evidenced a referral was received on 8/11/23 and the SOC visit was conducted on 8/14/23. The record failed to evidence the reason for delay in conducting an initial assessment. 3. During an interview on 10/28/24 beginning at 3:05 PM, the Clinical Manager stated the initial assessment should have been within 48 hours of the referral and she was unsure of the delay in SOC. 410 IAC 17-14-1(a)(1)(A)		will be responsible formonitoring the time frame between receipt of referral and the initialassessment/SOC to ensure compliance. A new section was added to the start ofcare audit tool used for client chart review to monitor for compliance. Thiswill be ongoing to ensure compliance with federal and state regulations andensure this deficiency does not recur. This deficiency was corrected as of 11/5/2024	
G0528	Health, psychosocial, functional, cognition	G0528	**G0528:**	2024-10-30

	484.55(c)(1) Standard: Content of the comprehensive assessment. The comprehensive assessment must accurately reflect the patient's status, and must include, at a minimum, the following information: (1) The patient's current health, psychosocial, functional, and cognitive status; Based on observation and interview, the RN failed to conduct a thorough and complete ongoing assessment for 1 of 1 home visit observations with a skilled professional performing the visit (Patient #1). Findings include: 1. During a home visit observation conducted with Patient #1 and RN 1 on 10/23/24 beginning at 9:05 AM, RN 1 was observed while performing a recertification assessment. RN 1 failed to assess Patient #1's skin. 2. During an interview on 10/24/24 beginning at 12:46 PM, RN 1 stated a skin assessment should be done every visit and she forgot to assess Patient #1's skin during the home visit observation on 10/23/24.		All clinical staff were educated/in-serviced oncomprehensive assessments and policy 2.05 on 10/30/24. The employee cited inthis deficiency was counseled on 10/30/24. All records cited at survey have been corrected withMD/practitioner notification of stated deficiency on 10/30/2024. The DON will completerandom supervision with skilled nurse visits to monitor comprehensiveassessments completed by clinical staff to ensure compliance with federal andstate regulations ensuring this deficiency does not recur. This deficiency was corrected as of 10/30/2024	

	3. During an interview on 10/25/24 beginning at 10:30 AM, the Clinical Manager stated a skin assessment should be completed at a minimum on every recertification visit. 410 IAC 17-14-1(a)(1)(B)			
G0572	Plan of care 484.60(a)(1) Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician or allowed practitioner refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician or allowed practitioner is consulted to approve additions or modifications to the original plan. Based on record review and interview, the agency failed to ensure the plan of care was reviewed by the attending practitioner at SOC for 1 of 1 discharge record reviewed who didn't have a signing practitioner (Patient #9). Findings include: 1. Patient #9's clinical record evidenced a SOC on 5/13/24	G0572	**G0572:** All clinical staff were educated on 11/6/24 of this citieddeficiency and policy 2.20. This policy was updated as of 11/6/24. The cited client is no longer an active client as he hasbeen discharged. This deficiency has been corrected as of 11/6/24 withre-notification to physician of stated deficiency. The DON will monitor compliance of policy 2.20 on an ongoingbasis to ensure compliance with federal and state regulations and ensure thisdeficiency does not recur. This deficiency was corrected as of 11/6/2024	2024-11-06

	and a POC for the certification period 5/13/24 to 7/12/24. The POC was created and signed by RN 1 on 5/13/24. The clinical record failed to evidence a signed POC was obtained for Patient #9. Patient #9 was discharged from the home health agency on 7/12/24 due to not having a signing doctor. 2. During an interview on 10/28/24 beginning at 2:55 PM, RN 1 reported she contacted Practitioner Q prior to the SOC visit to request an order for the initial assessment and faxed the POC to Practitioner Q after the SOC visit. The home health agency did not receive any signed orders from Practitioner Q after the SOC visit. She reported she contacted Entity P trying to obtain signed orders and was told Practitioner Q was no longer there and Patient #9 had been transferred to Entity S for medical care. 410 IAC 17-13-1(a)			
G0590	Promptly alert relevant physician of changes 484.60(c)(1) The HHA must promptly alert the relevant	G0590	**G0590:** All clinical staff were counseled and in-serviced on policy2.15 on 11/6/24.	2024-11-06

	physician(s) or allowed practitioner(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered. Based on record review and interview, the home health agency failed to ensure the physician was notified of the need to alter the POC related to possible discharge for 2 of 2 discharge for non-compliance records reviewed (Patients #7 and 8). Findings include: 1. The agency "Discharge/Transfer Policy", last updated July 2024, indicated prior to discharge the patient and attending physician shall be notified and a patient conference, with the participation of all appropriate disciplines, will be held to discuss the situation and any appropriate actions which could be taken. 2. Patient #7's clinical record included a POC for certification period 6/04/24 to 6/27/24. The POC indicated the patient was to receive HHA visits 1 hour a day, 7 days a week for 9 weeks. The record evidenced HHA Visits were not completed on 6/25/24 and 6/26/24. The record failed to include		All cited records in this deficiency are discharged. A newsection to the discharge audit tool has been added to monitor for compliance. This will be monitored by the Administrator and/or DON withevery discharge to ensure compliance with federal and state regulations andensure this deficiency does not recur. This deficiency has been corrected as of 11/6/2024	

	documentation of collaboration with the physician regarding POC frequencies needing to be altered due to possible discharge for non-compliance. During an interview on 10/25/24 beginning at 8:25 AM, Person O, an employee of Physician N, reviewed the medical record for Patient #7 and did not see any documentation from the home health agency regarding possible discharge for non-compliance prior to the 6/27/24 discharge. During an interview on 10/28/24 beginning at 3:05 PM, the Clinical Manager reported the clinical record for Patient #7 did not include any documentation of collaboration with the physician for possible discharge for non-compliance prior to the discharge. 2. Patient #8's clinical record included a POC for certification period 7/11/24 to 8/21/24. The POC indicated the patient was to receive HHA visits 1-2 hours a day, 5-7 days a week for 9 weeks. The record evidenced a HHA Visit was not completed on 8/21/24 and evidenced			

	documentation Patient #8 had refused personal care from the HHA for multiple visits and the physician was not notified. The record failed to include documentation of collaboration with the physician regarding POC frequencies needing to be altered due to possible discharge for non-compliance. During an interview on 10/28/24 beginning at 9:21 AM, RN 2 stated they thought they collaborated with the physician about possible discharge for non-compliance. The clinical record for Patient #8 failed to evidence any documentation of collaboration with the physician prior to discharge. 410 IAC 17-13-1(a)(2)			
G0682	Infection Prevention 484.70(a) Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases. Based on observation, record	G0682	**G0682:** Employees cited in this deficiency were counseled andre-educated on policy 5.0 (Hand Hygiene) on 10/30/24. A new section has been added to the "HHA complianceobservation" check	2024-10-30

	review, and interview, the agency failed to ensure employees followed standards of practice for hand hygiene to reduce the spread of infections for 2 of 3 home visit observations (RN 1 and HHA 1). Findings include: 1. The agency policy "Hand Washing/Hand Hygiene", last updated February 2019, indicated hand hygiene should be performed before donning gloves and after removing gloves. 2. During a home visit observation conducted with Patient #1 and RN 1 on 10/23/24 beginning at 9:05 AM, RN 1 was observed taking her cell phone out of her pocket to use timer to count Patient #1's respirations. RN 1 donned gloves and proceeded to assess Patient #1. RN 1 failed to perform hand hygiene prior to donning gloves. During an interview on 10/24/24 beginning at 12:46 PM, RN 1 stated hand hygiene should be performed before and after gloves. 3. During a home visit		compliance with stateddeficiency. The clinical manager will be responsible for ongoingmonitoring for compliance for home health aides at a minimum of once every 60days. The DON will be responsible for monitoring compliance for the skilledclinicians during skilled nurse visits. This monitoring will be ongoing at aminimum of once every 60 days to ensure compliance with federal and stateregulations ensuring this deficiency does not recur. This deficiency was corrected as of 10/30/2024	

	Patient #2 and HHA 1 on 10/24/24 beginning at 12:57 PM, HHA 1 was observed donning gloves after covering Patient #1 with a blanket. HHA 1 failed to perform hand hygiene prior to donning gloves. Later in the visit, HHA 1 walked to the bathroom to get Patient #2's deodorant. HHA 1 returned to the bedroom and donned gloves again to perform care. HHA 1 failed to perform hand hygiene prior to donning gloves. During an interview on 10/24/24 beginning at 1:42 PM, HHA 1 stated hand hygiene should be performed anytime hands are dirty, before and after gloves and before and after personal care. 4. During an interview on 10/25/24 beginning at 10:30 AM, the Clinical Manager relayed hand hygiene should have been performed before and after gloves. 410 IAC 17-12-1(m)			
G0800	Services provided by HH aide 484.80(g)(2)	G0800	**G0800:** The employee cited in this deficiency was counseled	2024-10-31

	A home health aide provides services that are: (i) Ordered by the physician or allowed practitioner; (ii) Included in the plan of care; (iii) Permitted to be performed under state law; and (iv) Consistent with the home health aide training. Based on observation, record review and interview, the home health agency failed to ensure the HHA provided services as ordered in the HHA care plan for 1 of 2 HHA home visit observations (Patient #3). Findings include: 1. Patient #3's clinical record for certification period 9/11/24 to 11/09/24 included a HHA care plan which indicated Patient #3 was to receive HHA visits 3 to 4 times a week. The aide care plan indicated the patient was to receive hair care and oral care every visit. During a home visit observation conducted with Patient #3 and HHA 2 on 10/24/24 beginning at 10:26 AM, observed HHA 2 give Patient #3 a shower. After the shower, HHA 2 dried the patient off, assisted with dressing, walked with the		andre-educated on policy 2.18 and HC-107 on 10/31/24. A new section has been added to the audit tool of "HHAcompliance observation". The clinical manager will be responsible for ongoingmonitoring for compliance at a minimum of at least once every 60 days. This monitoring will be ongoing to ensure compliancewith federal and state regulations ensuring this deficiency does not recur. This deficiency has been corrected as of 10/31/2024	

	and tucked Patient #3 in bed. HHA 2 failed to perform oral care and failed to comb Patient #3's hair. The HHA visit note for 10/24/24 indicated HHA 2 performed hair care and oral care during the home visit observation. HHA 2 failed to accurately document the HHA visit and failed to follow the HHA care plan. During an interview on 10/24/24 beginning at 2:20 PM, HHA 2 stated she reviewed the aide care plan daily and confirmed Patient #3's hair should have been combed after the shower. She also stated mouth care should be performed after meals, in the morning and at night. During an interview on 10/25/24 beginning at 10:30 AM, the Clinical Manager stated the HHA should follow the care plan and should have performed hair care and oral care during the home visit observation.			
G1024	Authentication 484.110(b)	G1024	**G1024:** All clinical staff were counseled and educated/in-servicedon	2024-10-29

	Standard: Authentication. All entries must be legible, clear, complete, and appropriately authenticated, dated, and timed. Authentication must include a signature and a title (occupation), or a secured computer entry by a unique identifier, of a primary author who has reviewed and approved the entry. Based on observation, record review and interview, the home health agency failed to ensure the HHA supervisory visits were performed and recorded accurately for 5 of 5 active records reviewed with HHA services (Patients #1, 2, 3, 5 and 6). Findings include: 1. The agency policy "Home Health Aide Supervision", last updated July 2018, indicated Supervision of services by a RN will be completed at least every 30 days while the client is receiving services and the aide will be present (1 of those 2 visits to be observed). 2. Patient #1's clinical record evidenced a SOC on 6/27/24 and included a POC for the certification period 8/26/24 to 10/24/24 with orders for HHA services 1 to 2 hours a day, 4 to 5 days a week for 9 weeks. The		HHA supervision visits and policy 2.48 on 10/29/24. All records cited at survey have been corrected with MD/practitionernotification of stated deficiency. A new process has been implementedas of 10/29/24 for HHA supervision visits and all clinical staff were educated onthe new process. A new section to clinical chart recertaudit tool has been added to monitor HHA supervisory visits. The DON shall be responsible for the ongoing monitoring ofthese corrective actions and ensure compliance withfederal and state regulations and ensure this deficiency does not recur. This deficiency has been corrected as of10/29/2024	

	following discrepancies: a) A home health aide supervisory visit was completed on Saturday 7/27/24 from 3:30 to 4:00 PM by RN 1. The HHA supervisory visit form stated the HHA was present and RN 1 educated HHA 6 on safety with ADL's and observed HHA 6 performing handwashing. The record failed to evidence a HHA visit was made by HHA 6 on 7/27/24. During an interview on 10/25/24 beginning at 11:16 AM, HHA 6 stated they do not work on Saturdays and was not present during the HHA supervisory visit on 7/27/24. During an interview on 10/25/24 beginning at 12:14 PM, RN 1 stated she thought the HHA was present and working for another agency while in Patient #1's home.			

	b) A home health aide supervisory visit was completed on 10/25/24 from 2:00 to 2:30 PM by RN 1. This visit note was given to Surveyor on 10/25/24 at 10:29 AM. The HHA supervisory visit form had an incorrect date and time listed on the form. During an interview on 10/25/24 beginning at 12:14 PM. RN 1 stated she dated and timed the HHA supervisory form incorrectly. She indicated the supervisory visit was completed on 10/23/24. 3. Patient #2's clinical record evidenced a SOC on 7/05/24 and included a POC for the certification period 9/03/24 to 11/01/24 with orders for HHA services 1 hour a day, 3 to 4 days a week for 9 weeks. The clinical record evidenced the following discrepancies: a) A home health aide supervisory visit was completed on Sunday 8/04/24 from 1:00 to 1:30 PM by RN 1. The HHA supervisory visit form stated the HHA was present and RN 1 educated HHA 1 on fall prevention, safe use of assistive devices and observed HHA 1			

	performing handwashing. The record failed to evidence a HHA visit was made by HHA 1 on 8/04/24. b) A home health aide supervisory visit was completed on 10/03/24 from 1:00 to 1:30 PM by RN 1. The HHA supervisory visit form stated the HHA was present and RN 1 educated HHA 1 on hand hygiene and observed HHA 1 performing handwashing. The record failed to evidence a HHA visit was made by HHA 1 on 10/03/24. During an interview on 10/24/24 beginning at 1:42 PM, HHA 1 stated she had not worked on the weekend, and she was not asked to come in on her day off to do the supervisory skills observation. During an interview on 10/25/24 beginning at 12:14 PM, RN 1 states she doesn't usually work weekends, and at 12:24 PM, RN 1 stated she thought the HHA was present and working for another agency while in Patient #2's home. 4. Patient #3's clinical record evidenced a SOC on 3/15/24 and included a POC for the			

	certification period 9/11/24 to 11/09/24 with orders for HHA services 1 hour a day, 3 to 4 days a week for 9 weeks. The clinical record evidenced the following discrepancies: a) A home health aide supervisory visit was completed on 8/12/24 from 4:00 to 4:30 PM by RN 1. The HHA supervisory visit form stated the HHA was present and RN 1 educated HHA 5 on fall prevention, use of assistive devices and observed HHA 5 performing handwashing. The record failed to evidence a HHA visit was made by HHA 1 on 8/12/24. b) A home health aide supervisory visit was completed on 9/11/24 from 4:00 to 4:30 PM by RN 1. The HHA supervisory visit form stated the HHA was present and RN 1 educated HHA 5 on fall prevention and observed HHA 5 performing handwashing. The record failed to evidence a HHA visit was made by HHA 5 on 9/11/24. During an interview on 10/24/24 beginning at 1:58 PM,			

on her day off to do the supervisory visit.

During an interview on 10/25/24 beginning at 12:33 PM, RN 1 stated the HHA was present for the HHA supervisory visits and was working for another agency while in Patient #3's home.

5. Patient #5's clinical record evidenced a SOC on 4/18/24 and included a POC for the certification period 10/15/24 to 12/13/24 with orders for HHA services 2 to 4 hours a day, 5 to 7 days a week for 9 weeks. The clinical record evidenced the following discrepancies:

a) A home health aide supervisory visit was completed on 9/19/24 from 9:15 to 10:15 AM by RN 2. The HHA supervisory visit form stated the HHA was present, and RN 2 educated HHA 4 and observed HHA 4 performing handwashing. The record evidenced a HHA visit was performed on 9/19/24 from 6:59 to 9:03 AM. The record failed to evidence HHA 4 was present during the RN supervisory visit beginning at 9:15 AM.

	b) A home health aide supervisory visit was completed on 10/03/24 from 3:00 to 4:00 PM by the Clinical Manager. The HHA supervisory visit form stated the HHA was present, and the Clinical Manager observed HHA 4 performing handwashing. The record evidenced a HHA visit was performed on 10/03/24 from 7:57 to 9:57 AM. The record failed to evidence HHA 4 was present during the RN supervisory visit beginning at 3:00 PM. During an interview on 10/25/24 beginning at 12:42 PM, the Clinical Manager stated HHA 4 was present while she was in the home, however HHA 4 was working for another agency during the HHA supervisory visit. c) A home health aide supervisory visit was completed on 10/17/24 from 7:00 to 8:00 AM by RN 2. The HHA supervisory visit form stated the HHA was present, and RN 2 observed HHA 4 performing handwashing. The record evidenced a HHA visit was performed on 10/179/24 from 8:06 to 10:06 AM. The record			

	failed to evidence HHA 4 was present during the RN supervisory visit beginning at 7:00 AM. d) During an interview on 10/28/24 beginning at 9:21 AM, RN 2 stated HHA 4 was present for the supervisory visits on 9/19/24 and 10/17/24. She relayed HHA 4 was working for another agency during the HHA supervisory visit. e) During an interview on 10/24/24 beginning at 1:52 PM, HHA 4 was unsure if she was present for the supervisory visits and if she was present, then she was probably working for another agency at that time. 6. Patient #6's clinical record evidenced a SOC on 8/14/23 and included a POC for the certification period 10/07/24 to 12/05/24 with orders for HHA services 1 to 3 hours a day, 5 days a week for 9 weeks. The clinical record evidenced the following discrepancies: a) A home health aide supervisory visit was completed on Saturday 9/07/24 from 3:00 to 3:50 PM by RN 3. The HHA supervisory visit form stated the			

	educated HHA 3 on range of motion and observed HHA 3 performing handwashing. The record evidenced a HHA visit was performed on 9/19/24 from 6:59 to 9:03 AM. The record failed to evidence a HHA visit was made by HHA 3 on 9/07/24. RN 3 is no longer employed by the home health agency and unavailable for an interview. During an interview on 10/24/24 beginning at 4:00 PM, Person M, family member of Patient #6, stated Patient #6 only received visits from the home health agency Monday through Friday, never on a weekend. 410 IAC 17-15-1(a)(7)			
N0000	Initial Comments This visit was for a State Re-licensure Survey of a Home Health provider. Survey Dates: October 22, 23,	N0000		

	24, 25, 28, 2024 12-month Unduplicated Skilled Admissions: 2			
N0458	Home health agency administration/management 410 IAC 17-12-1(f) Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following: (1) Receipt of job description. (2) Qualifications. (3) A copy of an employee's national/expanded criminal history background check pursuant to IC 16-27-2. (4) A copy of current license, certification, or registration. (5) Annual performance evaluations.	N0458	**N0458** 11/5/24 Staff responsible for ordering Criminal Backgroundchecks were counseled and educated on policy HB-130, IC 16-27-2 and newemployee audit process. 11/5/14-11/14/24 Employee charts were audited if out ofcompliance a new report was pulled. The employee cited at survey was corrected. 11/5/24 A new employee audit process will be implemented toprevent the deficiency from recurring. The Administrator will monitor each new hire employee recordfor compliance and to ensure this deficiency does not recur. Deficiency was corrected as of 11/5/24.	2024-11-05

Based on personnel file review and interview, the home health agency failed to ensure personnel files included a national/expanded criminal history background check for 1 of 1 active personnel file reviewed with a hire date within the last 2 months (HHA 7).

Findings include:

1. HHA 7's personnel file indicated a hire date of 7/24/24. The file failed to evidence a criminal background check had been conducted.

2. During an interview on 10/28/24 beginning at 10:29 AM, the Administrator confirmed the home health agency did not run a criminal background check on HHA 7 upon hire.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided.For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility.If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sarah Barton	RN/DON	11/18/2024 8:48:16 AM