STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K065	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELP AT HOME SKILLED CARE	1015 PROFESSIONAL BLVD SUITE B, EVANSVILLE, IN, 47714

(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: 04/23/2025-04/25/2025 & 04/28/2025 Active Census: 188 At this Emergency Preparedness survey, Help at Home Skilled Care was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR §484.102.	E0000		
G0000	INITIAL COMMENTS	G0000		

	This visit was for a Federal Recertification and State Re-Licensure survey of a Home Health Provider. Survey Dates: 04/23/2025-04/25/2025 & 04/28/2025 12-Month Unduplicated Skilled Admissions: 4 Fully Extended Survey was announced on 04/28/2025 at 11:35 AM. This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Refer to State Form for additional State Findings. **Abbreviations:** HHA-Home Health Aide POC-Plan of Care SOC- Start of Care RN-Registered Nurse PSA-Personal Service Agency			
G0436	Receive all services in plan of care 484.50(c)(5)	G0436	RNCM will review/revise and sign each HHA service plan. HHAto be notified of any changes made to the client	2025-06-05

	Receive all services outlined in the plan of care. Based on observation, record review and interview, the agency failed to provide services as ordered on the plan of care (POC) for 2 of 3 record reviews with an HHA home visit. (Patients #7, #8) Findings include: 2. During an observation on 04/24/2025 at 3:25 PM, HHA 5 waited in the home's living room, out of sight from Patient #7, until the patient ate and was ready to bathe. HHA 5 failed to prepare meals, observe the patient during mealtime, provide nail care, and perform light housekeeping.		service plan, and the updatedplan will be placed in client home chart. Administrator to educate all caregivers to follow the service planas ordered and notify the RNCM if any changes need to be made. (completed on 4/30/25) In the future this deficiency will becorrected by, the Administrator educating all RNCMsand the Clinical Assistant on how to pull daily visit sheets for review, whatdocumentation is required and how to chart the QA of timesheets. The Administrator will audit 100%of active clients for updated service plans. 100% of all timesheets will beaudited at least every 30 days by Clinical Assistant with Administratoroversight. RNCM to follow up on any HHA documentation that does not follow theclient specific service plan.	

	During an interview on 04/24/2025 at 3:25 PM, HHA 5 indicated she did not have a POC and did not have a list of tasks she provided during the visit. The HHA 5 indicated she usually does a shower, watches TV, listens to the radio, and has done laundry before. 3. A record review of Patient #7 included the following: A POC with a certification period of 02/26/2025 - 04/26/2025 indicates that the aide should assist with all ADLs, such as bathing, hair care, dressing, nail care, incontinence care, and light housekeeping. A 04/24/2025 "Daily Visit Sheet" indicates that the aide completed preparing meals, monitoring the patient during mealtime, and providing nail care and light housekeeping during the home visit on 04/25/2025. A 09/05/2023 "Business			

	Associate Agreement" indicates Help at Home to provide personal care, light housekeeping, and ADL assistance. During an interview on 04/25/2025 at 11:55 AM, the Administrator indicated that the aides should provide all tasks listed on the POC and that they are to follow the POC; they should not document the services they did not provide during the home visit. The Administrator reviewed HHA 5's documentation from Daily Visit Sheet 04/24/2025 and confirmed that the aide documented she completed light housekeeping, nail care, monitoring patient during mealtime, and meal preparation. 1. A 01/27/2025 revised "Home Health Aide Care Service Plan" policy indicated that the HHA staff will follow the identified plan. The policy indicated that staff should place a copy of the Care Service Plan in the patient's home. The HHA staff should document the service			

	Daily Visit as directed in the Home Health Aide Care Service Plan. 2 3. The clinical record for Patient #8, SOC date 03/31/2025, was reviewed on the electronic medical record (EMR). The record evidenced that Patient #8 received HHA, Attendant Care, and Homemaker services. A review of the POC included orders for HHA services, 4 hours a day, six times a week. A review of the Plan of Care Service Plan indicated that Patient #8 should receive a tub bath or shower 6 times a week. A review of the Daily Visit Notes indicated the HHA did not provide a tub bath or shower on the following dates: 3/31/2025. 04/01/2025, 04/09/2025, 04/10/2025, 04/14/2025, 04/15/2025, 04/16/2025, 04/17/2025, 04/19/2025, 04/21/2025, 04/22/2025, 04/23/2025, and 04/24/2025. During an interview on 04/24/2025 at 2:30 PM, HHA 1 reviewed the Plan of Care Service Plan with the surveyor. HHA 1 stated she gives Patient			

	times a week on Mondays, Wednesdays, and Fridays. HHA 1 could not explain why the Plan of Care Service Plan indicated a tub/shower 6 times a week. 4. During an interview on 04/25/2025 at 9:55 AM, the Administrator provided the Daily Visit Notes after two requests. She stated that the staff should have updated the Plan of Care Service Plan to reflect the tasks the HHA was supposed to do in the home.			
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 review, and interview, the agency failed to ensure staff wore gloves during patient care and failed to perform hand hygiene before applying gloves and after removing gloves for 2 of 3 home visit observations. (Patients #7, #8)	G0682	On 4/30/2025 the Administrator provided written education toall caregivers on the Evansville license regarding proper hand hygeine. The Administrator scheduled HHAs #5 and 1 to demonstrate properhand hygeine in a supervised setting. RN will observe and document competencewith this skill. Proof of compliance with this observation will be maintainedin the caregiver record prior to 5/16/2025. The deficiency will be corrected in the future by eachcaregiver	2025-05-16

	Findings include: 2. During an observation on 04/24/2025 at 3:25 PM, HHA 5 assisted Patient #7 with toileting with gloved hands, removed gloves, and touched their hand on the shower facet handle. The HHA 5 failed to perform hand hygiene after removing gloves and before touching clean surfaces. HHA 5 washed Patient #7 hair with gloved hands, removed gloves, and re-gloved. HHA 5 failed to perform hand hygiene after removing gloves and before re-gloving. HHA 5 washed Patient #7 legs, arms, chest, and back, then removed gloves and re-gloving. HHA 5 failed to perform hand hygiene after removing gloves and before re-gloving. HHA 5 washed Patient #7 private area. HHA 5 removed gloves, helped Patient #7 out of the shower, and dried the patient with a towel. HHA 5 failed to practice hand hygiene after removing gloves and before touching the clean toilet. During an interview on 04/24/2025 at 3:25 PM, HHA 5 indicated she should have hand		completing hand hygiene education upon hire and annually. Movingforward, RNCM will observe hand hygiene and re-educate, if applicable, at leasttwice per year using home observation form. Proof of compliance with thisobservation will be maintained within the EMR.	

	hygiene before and after gloving. HHA 5 indicated the agency had annual education that included hand hygiene. 5. During an interview on 04/25/2025 at 11:55 AM, the Administrator indicated hand hygiene should be performed upon arrival, with glove change, after touching the patient, going from dirty to clean, before touching the patient, and after touching dirty clothes. 1. A revised 01/27/2025 policy titled "Infection Prevention and Control Plan" requires staff to wear gloves during patient contact. The policy stated that staff must perform hand hygiene after removing their gloves. 2. 3. During an observation on 04/24/2025 at 2:30 PM, HHA 1 failed to wear gloves and perform hand hygiene before and after transferring Patient #8 from the recliner to bed. During an interview on 04/24/2025 at 2:45 PM, HHA 1 stated she doesn't use hand			

	sanitizer because it gets old and becomes sticky. She stated she washes her hands when providing direct care, but she did not indicate why hand hygiene was not done during the visit. 4. During an interview on 04/25/2025 at 1:30 PM, the Administrator stated staff should wear gloves and perform hand hygiene with direct patient contact, including when transferring patients. 5. 410 IAC 17-12-1(m)			
G0974	Direct support and administrative control 484.105(d)(2) The parent HHA provides direct support and administrative control of its branches. Based on record review and interview, the agency failed to ensure clarity and formal documentation of lines of authority, delegation of responsibility, and clear administrative control of the branch location for 1 of 1 home	G0974	Branch Manager job description updated 5/13/2025. Administratorreviewed the updated JD with each Branch Manager for the Evansville and NewAlbany locations. Signed copy of updated BM Job Description will be uploaded toemployee personnel file. Organizational chart was updated on 5/13/2025. Administratorreviewed the updated organizational chart	2025-05-13

	health agency with a branch location. Findings include: A revised 02/01/2022 Branch Manager 1's job description indicated they oversee the day-to-day operations and report to the Director of Regional Operations. The acceptance letter states she oversees the Evansville location (parent agency). The job description did not indicate that the Branch Manager was to report to the Administrator. During an interview on 04/23/2024 at 12:33 PM, Branch Manager 1 stated she was dually employed and implied she manages the New Albany branch. During an interview on 04/28/2025 at 12:28 PM, the surveyor asked the Administrator why the "New Albany" Branch office showed a direct connection to the "Evansville License" but no connection to the rest of the organizational chart. She explained that this indicated		andNew Albany locations, and a copy of the document was provided to each staffmember. In the future this deficiency will be corrected by, the Administrator reviewing the updated Job Description for any new Branch Manager added to the license and ensuring the signed document is maintained withing the employee file. The Administrator will ensure any new admin staff hired to the license receives a copy of the updated organizational chart and will review its contents with the new employee at time of hire.	

	that the branch operates under the Evansville license. She stated that Branch Manager 2 reports to someone associated with the Evansville license, while Branch Manager 1 does not supervise the New Albany office and is managed by Branch Manager 2. She stated that anyone can report to whoever is on the chart.			
G0982	Skilled services furnished 484.105(f) Standard: Services furnished. Skilled nursing services and at least one other therapeutic service (physical therapy, speech-language pathology, or occupational therapy; medical social services; or home health aide services) are made available on a visiting basis, in a place of residence used as a patient's home. An HHA must provide at least one of the services described in this subsection directly, but may provide the second service and additional services under arrangement with another agency or organization. Based on record review and interview, the agency failed to maintain full operational capacity as a certified home health agency under the Indiana Medicaid program, which adopts the Medicare Conditions of Participation. Although the	G0982	Administrator to educate all admin staff and intake referralteam regarding services provided by agency to include HHA and skilled nursing. In the future this deficiency will be corrected by the Administratorreviewing 100% of any new skilled nursing lead and will accept as appropriatefollowing the Acceptance to Service Policy. Additionally, the Administrator will review all leads/referrals at least onceper week.	2025-05-13

	limited number of existing skilled patients, it has refused all new skilled admissions for an extended period without documentation of temporary suspension, licensure limitation, or resource-based justification. This restricts service access to eligible Medicaid beneficiaries and does not meet the operational expectations for a certified provider. Findings include: On 04/23/2025 at 9:41 AM, the surveyor called the agency as listed on their website. When asked about skilled care, the staff representative who answered the phone stated they do not have skilled services. On 04/23/2025 at 10:00 AM, the surveyor called the New Albany branch to inquire about skilled care services. The staff member stated they do not offer skilled care nursing services and expressed uncertainty about the services available at the Evansville location.			

	On 04/23/2025, at 11:20 AM, the surveyors entered the agency located on Professional Boulevard. The Recruiting Specialist informed the surveyors that Help at Home Skilled Care operates at that address but does not offer skilled services. She was unsure of the Administrator or Alternate Administrator's whereabouts, but stated she would call them. During the entrance conference on 04/23/2025 at 11:33 AM, the Alternate Administrator stated stated they have four skilled patients at the branch location and zero at the parent agency in Evansville. She stated the agency can provide skilled services, but is not offering them. She stated there were no staffing issues. She stated that the agency collaborates with other skilled agencies to manage care. The surveyor reviewed the agency's brochure on 04/23/2025, which indicated that the agency offers skilled nursing services including ventilator care, tracheotomy care, wound care, medication			

	dressing, and bathing. The pamphlet indicated higher-level medical care was available, including blood draws, wound care, catheter changes, diabetic care, intravenous services, colostomy care, medication set-up, skilled skin care, and skilled transfers. During an interview on 04/23/2025 at 1:03 PM, the RN Nurse Supervisor stated that she could not comment on whether the agency admitted patients for skilled nursing services. She mentioned that she would need to consult the Administrator before answering. During an interview on 04/23/2025 at 1:30 PM, the Branch Manager for the parent company stated that the agency does not provide skilled services and only has Medicaid patients. During an interview on 04/23/3035 at 2:00 PM, the RN Supervisor stated they have had 7 Skilled admissions since their last survey in 2022. At 3:00 PM, the RN Nurse Supervisor stated that they used the Help at Home brochure for marketing purposes. During an interview on			

	04/25/25 at 1:20 PM, the Administrator indicated the last skilled patient admitted to the agency was before 12/2023; she did not review skilled nursing patient referrals. Referrals are not added to the EMR system until the referral team (non-clinical staff) and admission team (non-clinical staff) review and eliminate the new referrals. The Administrator indicated that once the referral and admission teams have completed their reviews, she can access a list of acceptable referrals; she doesn't receive a list of all the patients referred to the agency. The Administrator indicated that there is a list of rejected referrals, but she does not have access to it.			
G1022	Discharge and transfer summaries 484.110(a)(6)(i-iii) (i) A completed discharge summary that is sent to the primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any) within 5 business days of the patient's discharge; or (ii) A completed transfer summary that is sent within 2 business days of a planned transfer, if the patient's care will be immediately continued in a health care facility; or	G1022	On 4/28/2025 the Discharge policy was discussedwith the Governing Body after the Administrator reviewed regulation requirements.The Governing Body to review and update policy: Client Discharge Process _HAHto remove unnecessary items listed in the discharge summary. Administrator to educate	2025-05-13

	(iii) A completed transfer summary that is sent within 2 business days of becoming aware of an unplanned transfer, if the patient is still receiving care in a health care facility at the time when the HHA becomes aware of the transfer. Based on record review and interview, the agency failed to send discharge summaries within five business days of the patient's discharge and failed to include detailed health information about the patient for 2 of 3 closed records reviewed. (Patient #5, #9) Findings include: 1. A 01/16/2025 policy titled "Client Discharge Process" indicates the staff will complete a discharge summary to include the following: a. Client status at the time of admission to the agency b. Statement of care and interventions provided and outcomes of care c. Status at discharge/last visit/current medications, therapies, and continuing care needs d. Name of person or		regarding discharge policy update. Administrator to educate allRNCMs regarding requirements of discharge summary including proof of being sentto MD within 5 days. Administrator provided discharge checklistto assist in completing the discharge per policy. In the future this deficiencywill be corrected by, the Administrator reviewing 100% of all discharges toensure compliance with discharge planning and following policy. Additionally,discharges will be tracked and reviewed as part of agency QAPI program.	

	responsibility for care e. Instructions and referrals were given to the client/family/caregiver f. Reason for discharge and date Of discharge The agency will send a discharge summary to the MD within 5 business days. 2. The record review of Patient # 5 included a discharge summary that failed to evidence the client's status upon admission, interventions provided and outcomes, status at discharge, last visit, current medication, continuing care needs, instructions/referrals given, and the physician was notified within 5 days of discharge. During an interview on 04/25/2024 at 12:37 PM, the Administrator indicated that the discharge summary in Patient #5's record was missing essential information related to the discharge summary. She			

	proof in the record that the agency had notified the physician within 5 days of Patient #5's discharge. 3. MC 410 IAC 17-15-1 (a)(7) 3. The clinical record for Patient #9, SOC date 03/23/2044, certification period 01/12/2024-03/11/2024, evidenced a Discharge Summary date of 03/04/2024. The Discharge Summary failed to include several essential elements: the name of the physician responsible for the home health plan of care, the reason for the patient's admission to home health, the type and frequency of services provided, laboratory data, the medications the patient was taking at the time of discharge, the patient's condition upon discharge, the outcomes related to meeting the goals outlined in the plan of care, and any post-discharge instructions for the patient and family. Furthermore, the agency could			

	not provide evidence or confirm that it sent the Discharge Summary to the physician or any other healthcare professional. During an interview on 04/25/2025 at 2:00 PM, the Administrator reviewed Patient #9's record. She stated the discharge summary did not contain specific information.			
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	The administrator will audit 100% ofactive caregiver files to include HHA, LPN, and RN field staff for requiredhiring documents to include job description, orientation, and TB documentation.Any file found to be out of compliance during the audit review, will be broughtinto compliance by obtaining the missing documents and uploading to the caregiver'spersonnel file. The deficiency will be corrected in thefuture by use of the attached new hire audit tool. Administratorto audit all new hires in the next 30 days. If any personnel files are NOT in compliance, the Administrator will continue to audit all new hires for an additional 30 days. If 100% of personnel files are in compliance, the Administrator will reducethe number of files audited to 2	2025-06-05

	Based on record review and interview, the agency failed to maintain clinical employee records on 4 of 8 clinical employee records reviewed. (RN 1, LPN 1, HHA 2, HHA 7) Findings include: 1. A signed 02/01/2022 Branch Manager job description indicated the Manager supervisory responsibilities include participating in the hiring and training of staff at the agency. 2. The personnel record reviews for RN 1, hire date 12/10/2008, failed to evidence the RN job description and orientation documents.		new hires weekly for the next 30 days. Once 100% of personnel files are within compliance and files have been audited by Administrator for at least 60 days, the Administrator will no longer audit new hire files. 100% new hire files will continue to be audited by the Branch Manager and the Recruiting Specialist.	

	During an interview on 04/28/2025 at 12:37 PM, The Alternate Administrator indicated that the RN 1 personnel file was missing items in storage at the branch office and inaccessible. 3. The personnel record reviews for LPN 1, hire date 12/10/2013, failed to evidence orientation documents and LPN job description. 4. The personnel record reviews for HHA 2, hire date 06/12/2017, failed to evidence orientation documents. 5. The personnel record reviews for HHA 7, hire date 02/09/2023, failed to evidence orientation documents. 6. During an interview on 04/28/2025 at 3:55 PM, The Administrator confirmed she had provided all employee documents; if documents were not in the provided materials, the agency did not have them.			
N0464	Home health agency administration/management 410 IAC 17-12-1(i)	N0464	The administrator will audit 100% of active caregiver files to include HHA, LPN, and RN field staff for required hiring documents to include job description, orientation, and TB documentation. Any file found to be out of compliance during the audit review, will be brought into compliance by obtaining the	2025-06-05

	Rule 12 Sec. 1(i) The home health agency shall ensure that all employees, staff members, persons providing care on behalf of the agency, and contractors having direct patient contact are evaluated for tuberculosis and documentation as follows: (1) Any person with a negative history of tuberculosis or a negative test result must have a baseline two-step tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual has documentation that a tuberculin skin test has been applied at any time during the previous twelve (12) months and the result was negative. (2) The second step of a two-step tuberculin skin test using the Mantoux method must be administered one (1) to three (3) weeks after the first tuberculin skin test was administered. (3) Any person with: (A) a documented: (i) history of tuberculosis; (ii) previously positive test result for tuberculosis; or (iii)completion of treatment for tuberculosis; or (B) newly positive results to the tuberculin skin test; must have one (1) chest rediograph to exclude a diagnosis of tuberculosis. (4) After baseline testing, tuberculosis screening must: (A) be completed annually; and (B) include, at a minimum, a tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual was subject to subdivision (3). (5) Any person having a positive finding on a tuberculosis evaluation may not: (A) work in the home health agency; or (B) provide direct patient contact;		missing documents and uploading to the caregiver's personnel file. The deficiency will be corrected in the future by use of the attached new hire audit tool. Administrator to audit all new hires in the next 30 days. If any personnel files are NOT in compliance, the Administrator will continue to audit all new hires for an additional 30 days. If 100% of personnel files , the Administrator will reducethe number of files audited to 2 new hires weekly for the next 30 days. Once 100% of personnel files are within compliance and files have been audited by for at least 60 days, the Administrator will no longer audit new hire files. 100% hire files will continue to be audited by the Branch Manager and the Recruiting Specialist.	

unless approved by a physician to work.

(6) The home health agency must maintain documentation of tuberculosis evaluations showing that any person:

(A) working for the home health agency; or

(B) having direct patient contact;

has had a negative finding on a tuberculosis examination within the previous twelve (12) months.

Based on record review and interview, the agency failed to ensure employees were given a 2nd step baseline tuberculosis (TB) (contagious disease) skin test before first patient contact on 6 of 7 clinical employee records with the potential to affect all active clinical employees. (RN 1, LPN 1, HHA 1, HHA 2, HHA 6, HHA 7)

Findings include:

1. A revised 01/22/2025 policy titled "Tuberculosis Testing" indicates that employees who have direct patient contact undergo tuberculosis (TB) screening by collecting a baseline 2-step skin test. An employee can provide a TB test from the prior 12 months, and

TB skin test upon hire. The agency will maintain documentation of TB testing in the employee records. The policy states that the agency will conduct an annual risk assessment.

2. An untitled document provided by the Administrator includes staff name, skill Category, Hire Date, and First Services Date.

3. The personnel record reviews of RN 1, hire date 12/10/2008, unknown first patient contact date, failed to evidence a second step TB Skin Test Screening upon hire and before first patient contact.

During an interview on 04/28/2025 at 12:37 PM, The Alternate Administrator indicated that the RN 1 personnel file was missing items in storage at the branch office and inaccessible.

4. The personnel record reviews of LPN 1, hire date 12/10/2013, failed to evidence an annual TB risk assessment.

5. The personnel record reviews of HHA 1 hire date 03/18/2025, unknown first patient contact

date, failed to evidence a second step TB Skin Test Screening upon hire and before first patient contact.

6. The personnel record reviews of HHA 2, hire date 06/12/2017, unknown first patient contact date, failed to evidence a second step TB Skin Test Screening upon hire and before first patient contact. The record failed to evidence an annual TB risk assessment.

7. The personnel record reviews of HHA 6, hire date 04/08/2025, unknown first patient contact date, failed to evidence a second step TB Skin Test Screening upon hire and before first patient contact.

8. The personnel record reviews of HHA 7, hire date 02/09/2023, unknown first patient contact date, failed to evidence a second step TB Skin Test Screening upon hire and before first patient contact.

9. During an interview on 04/28/2025 at 1:39 PM, The Administrator confirmed the first service date on the untitled document provided was the employee's first patient contact

	reviewed HHA 1 personnel record and determined that the first service date (03/18/2025) was not the first patient contact date (03/30/2025). 10. During an interview on 04/28/2025 at 3:55 PM, The Administrator confirmed she had provided all employee documents; if documents were not in the provided materials, the agency did not have them.			

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
Amber Armuth	Governing Body Member	5/13/2025 1:53:12 PM