

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/28/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/16/2010
NAME OF PROVIDER OR SUPPLIER COLONIAL MANOR CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2365 NASHVILLE ROAD BOWLING GREEN, KY 42101	
(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
F 000	INITIAL COMMENTS An annual survey was conducted on 04/14-16/10 and a Life Safety Code survey was conducted on 04/14/10 to determine the facility's compliance with federal regulatory requirements. Deficiencies were cited with the highest scope and severity being an "F".	F 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Colonial Manor Care and Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's	F 157	F 157 Notification of Change Resident #12 no longer resides at the center. Residents with a change of condition were reviewed for physician notification by the Director of Nursing, using the change of condition reports completed by 05/03/2010. The Director of Nursing provided the licensed nurses re-education on 05/03/2010 regarding physician notification of change in condition and to obtain a physician order before administering any medications. The 24 hour change of condition report is reviewed at the clinical morning meetings by the Director of Nursing or Assistant Director of Nursing. On weekends, this information is reviewed by the licensed nurse supervisor to validate timely physician notification. The Director of Nursing will monitor, weekly for 4 weeks, the 24 hour change of condition reports and the residents' medical records to validate timely notification of change in conditions. The results of the audits will be brought to the Quality Assurance Committee to determine the need for further recommendations. Compliance date:	05/04/2010

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE

Administrator

(X6) DATE

5/5/10

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 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/28/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/16/2010
NAME OF PROVIDER OR SUPPLIER COLONIAL MANOR CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2365 NASHVILLE ROAD BOWLING GREEN, KY 42101		
(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	
F 157	<p>Continued From page 1 legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to consult with the resident's physician when there was a change in the resident's condition, which had the potential for requiring commencement of a new treatment for one resident (#12) in the selected sample of 12. Resident #12 exhibited emotional distress related to the inability to pass hard stool from the rectal vault. The nurse removed the stool manually and gave the resident an enema without first consulting with the physician and without current orders. Findings included:</p> <p>Resident #12 was admitted on 12/03/09 with diagnoses to include Prostatic Cancer with Bone Metastasis and Acute Myocardial Infarction. The admission Minimum Data Set (MDS) revealed the resident was cognitively independent with decision making and needed limited to extensive assistance of one to two staff members with activities of daily living.</p> <p>A review of the nurses notes, dated 12/09/09 at 8:00 PM, revealed the resident was in a panic and needed to have a bowel movement. Registered Nurse (RN) #1 digitally removed a piece of hard, "impacted stool" and administered an enema.</p> <p>An interview, on 04/15/10 at 3:00 PM, with RN #1 revealed the RN's definition of a fecal impaction was "a hard, large ball of stool the resident could not remove by him/herself." The resident was in a panic state and the RN wanted to help the resident get some relief. RN #1 stated she</p>	F 157			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/28/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/16/2010
NAME OF PROVIDER OR SUPPLIER COLONIAL MANOR CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2365 NASHVILLE ROAD BOWLING GREEN, KY 42101	
(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
F 157	Continued From page 2 ausculted (listened to) the resident's bowel sounds prior to the removal of stool manually. However, RN #1 stated she did not recall notifying or consulting with the resident's physician prior to the actions taken and provided no evidence of physician orders authorizing the procedures. A review of the physician orders revealed no evidence of orders for an enema or digital removable of stool. An interview, on 04/15/10 at 4:08 PM, with the Director of Nurses revealed the unwritten policy of the facility required the RN to notify the physician and obtain orders prior to manual removal of stool and the administration of an enema.	F 157		
F 371 SS=F	483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined, the facility failed to store, prepare, distribute and serve food under sanitary conditions related to unacceptable thermometer calibration and food temperatures; food uncovered on the tray line for 40 minutes, prior to serving; meat thawing in a food splattered sink near the dirty dish sprayer and unacceptable	F 371	F371 Sanitary Conditions – Food Prep & Service The facility must store, prepare, distribute, and serve food under sanitary conditions. The Macaroni salad was not served and was discarded. It was replaced on the menu with tomato soup. The lettuce and tomatoes were not served and were discarded; they were replaced at meal service. The sanitizer solution was discarded and was replaced with fresh sanitizer. The linoleum tiles beneath the dishwasher were replaced immediately. Any broken, missing, stained or damaged tile was replaced on 05/03/2010. The two compartment sink was cleaned and the cleaning schedule was reviewed with all dietary staff on 05/03/2010. The dishwasher racks were replaced on 05/03/2010. The Dietary manager identified a new location for storage of the dish washer racks on 05/03/2010. A sanitation audit was conducted by the Administrator and Dietary manager to ensure all areas of sanitation were identified and addressed.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/28/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/16/2010
NAME OF PROVIDER OR SUPPLIER COLONIAL MANOR CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2365 NASHVILLE ROAD BOWLING GREEN, KY 42101		
(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	
F 371	<p>Continued From page 3</p> <p>sanitizer chemstrip levels in the sanitizer bucket.</p> <p>A review of the Census and Conditions form dated 04/15/10, revealed the facility census was 48. It was determined 46 of 48 residents were served food stored and prepared in the facility kitchen. Finding include:</p> <p>1. An observation, on 04/14/10 at 5:00 PM, of the preparation and food temperatures on the tray line for the supper meal revealed the macaroni salad was 60 degrees Farenheit (F). The macaroni salad was placed back in the freezer.</p> <p>An interview, on 04/15/10 at 8:25 AM, with the Dietary Manager revealed the Cook had calibrated the thermometer to 40 degrees F, instead of 32 degrees F, and that made the temperature of the macaroni inaccurate.</p> <p>2. Lettuce and sliced tomatoes were observed uncovered on a stainless steel tray from 4:50 PM until 5:30 PM.</p> <p>3. An observation of the sanitizer bucket, on 04/14/10 at 4:40 PM and 04/15/10 at 12:15 PM, revealed the bleach utilized for sanitation was tested using a chemstrip for bleach and did not indicate bleach in the solution.</p> <p>An interview with the Regional Dietician, on 04/15/10 at 12:20 PM, revealed the bleach in the sanitizer bucket "dissipated" after 15 minutes and would not be measurable.</p> <p>4. An observation of the kitchen, on 04/14/10 at 5:45 PM, revealed four linoleum tiles that were buckled (raised) under the dishwasher.</p>	F 371	<p>F371 Sanitary conditions: Cont.</p> <p>All dietary staff was re-educated on food temperatures and tray line start times on 05/03/2010. All dietary staff was re-educated on food safety which included sanitizer concentration and coving food items until service on 05/03/2010. The dietary manager and dietary staff were re-educated on thermometer calibration on 05/03/10.</p> <p>The administrator and Nutritional Services Director will monitor using a 50 point sanitation audit 3x per week for three weeks and then monthly thereafter. All results will be reported to the Quality Assurance Committee on a monthly basis for further recommendations.</p> <p>Compliance date:</p>	05/04/10	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/28/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/16/2010
NAME OF PROVIDER OR SUPPLIER COLONIAL MANOR CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2365 NASHVILLE ROAD BOWLING GREEN, KY 42101		
(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	
F 371	Continued From page 4 5. Throughout the kitchen area were stained and worn tiles. Dirt and debris were observed around the sink and stove bases with broken and missing tiles and a black substance around the tile edges. 6. A two-compartment sink was observed splattered with food particles. 7. Debris was observed around two-five pound packages of hamburger meat that was thawing under running water. 8. Five to eight plastic dishwasher racks, coated with a blackened substance, were stacked near the thawing meat in the next sink. The garbage disposal and dirty-dish sprayer had debris near the sinks area. An interview, on 04/15/10 at 12:30 PM, with the Regional Dietician revealed the blackened substance was lime build-up. The racks were clean and there was no place to store racks in the small kitchen area. There was only a two-compartment sink for food preparation and a hand wash sink.	F 371			
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428	F 428 Pharmacy Services Resident #8's medication order for Ativan was reviewed by the physician and discontinued before 05/03/2010. Residents receiving psychoactive medications were reviewed by Consultant Pharmacist, for medical necessity of the psychoactive medications on 05/03/2010.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/28/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/16/2010
NAME OF PROVIDER OR SUPPLIER COLONIAL MANOR CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2366 NASHVILLE ROAD BOWLING GREEN, KY 42101	
(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
F 428	<p>Continued From page 5</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interviews and record review, it was determined the facility failed to ensure the pharmacist review included reports of all irregularities to the attending physician for one resident (#8), in the selected sample of 12. Resident #8 had a "standing" order for Ativan (anti-anxiety) to be administered by intramuscular (IM) injection for behavior. Findings include:</p> <p>Resident #8 was admitted to the facility, on 10/01/06, with diagnoses to include Alzheimer's Disease and Dementia with Behavioral Disturbances.</p> <p>A review of Resident #8's Minimum Data Set (MDS) assessment, dated 03/05/10, revealed the resident had behaviors which included physically abusive behavior, socially inappropriate/disruptive behavior, and resisted care one to three days in the seven day assessment period. The MDS assessment revealed the behaviors were not easily altered.</p> <p>A review of Resident #8's physician orders, dated 09/23/09, revealed an order for Ativan 0.5 milligram (mg) by mouth (po) or intramuscular (IM) times one dose now. There was also an order, dated 09/28/09, for Ativan 0.5 mg po or IM twice a day as needed (prn) for anxiety/agitation. This order was clarified, on 09/30/09, to read Ativan 0.5 mg po prn for agitation or Ativan 0.5 mg IM twice a day prn agitation, if will not take the po medication.</p> <p>A review of the clinical record revealed the only pharmacy recommendation related to the Ativan</p>	F 428	<p>F428 Cont.</p> <p>The Medication regimen review process was reviewed by the administrator and pharmacist in regards to psychoactive medications. The pharmacist was re-educated by the Administrator on the need for monthly reviews of psychoactive medications and providing the attending physicians with appropriate pharmacy recommendations by 05/03/2010.</p> <p>The Director of Nursing will monitor by completing monthly audits x 3 months of the psychoactive medications to ensure they have been reviewed with recommendations by the pharmacist. The results of the audits will be brought to the Quality Assurance Committee for further recommendations.</p> <p>Compliance date:</p>	05/04/2010

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/28/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/16/2010
NAME OF PROVIDER OR SUPPLIER COLONIAL MANOR CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2365 NASHVILLE ROAD BOWLING GREEN, KY 42101		
(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	
F 428	<p>Continued From page 6</p> <p>was dated 03/26/10, and recommended both the po and IM doses of Ativan be discontinued, due to lack of use within the previous 60 days.</p> <p>An interview with the Consultant Pharmacist, conducted 04/16/10 at 2:40 PM, revealed the consultant was aware of the Ativan ordered for IM administration but had made no recommendations regarding the medications use or route of administration, prior to the one dated 03/26/10. The pharmacist revealed she had reviewed the recommendations from the psychiatric follow-up services the resident received. Because the outside agency had indicated a trial dose reduction was contraindicated, she had not made any recommendations regarding the Ativan for Resident #8. She also revealed she rarely saw a standing order for IM medications for behavior in long term care facilities, but after reviewing the order it did not sent up a "red flag" for her. She stated while she could not say it as a blanket statement, she would generally not make any recommendations regarding psychoactive medications for a resident, if the resident was receiving psychiatric services.</p> <p>A review of the consultant services contract, signed and dated 09/24/07, revealed among other services the consultant was to review the drug regimen of each facility resident and report in writing any irregularity to the facility Administrator, Medical Director, and Director of Nursing services; and the resident's physician.</p> <p>An interview with the facility Medical Director, conducted 04/16/10 at 1:55 PM, revealed the Medical Director was unaware of the standing order for IM administration of Ativan for</p>	F 428			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/28/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/16/2010
NAME OF PROVIDER OR SUPPLIER COLONIAL MANOR CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2365 NASHVILLE ROAD BOWLING GREEN, KY 42101		
(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	
F 428	Continued From page 7 agitation/anxiety. She further stated she would expect the staff to notify the physician if a resident's behavior was escalating to the point they required an IM medication.	F 428			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/13/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185048	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/14/2010
NAME OF PROVIDER OR SUPPLIER COLONIAL MANOR CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2365 NASHVILLE ROAD BOWLING GREEN, KY 42101		
(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	
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted on 04/14/10 to determine the facility's compliance with Title 42, Code of Federal Regulations, 482.41(b) (Life Safety from Fire) relating to NFPA 101 Life Safety Code 2000 Edition. No deficiencies were identified during this survey..	K 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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 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.