| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| BEDFORD CARE CENTER OF HATTIES | #10 MEDICAL BOULEVARD HATTIESBURG, MS 39401 |

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| F 000 | INITIAL COMMENTS<br><br>The State Agency (SA) conducted a recertification survey from 08/13/18 through 08/16/18. During the survey the SA determined the facility was not in compliance with the Medicare and Medicaid Requirements for Participation. The SA cited deficiencies at F550, F656, F686, and F680.<br><br>The census at the time of entrance was 133, and the facility was certified for 152 beds. | F 000 | | |
| F 550 SS=D | Resident Rights/Exercise of Rights<br>CFR(s): 483.10(a)(1)(2)(b)(1)(2)<br><br>§483.10(a) Resident Rights.<br>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.<br><br>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br><br>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.<br><br>§483.10(b) Exercise of Rights. | F 550 | | 10/9/18 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 09/18/2018

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.

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| F 550 | Continued From page 1<br>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.<br><br>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.<br><br>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure Resident #25's dignity as evidenced by failure to provide coverage for the resident's indwelling urinary catheter drainage bag, for one (1) of four (4) residents reviewed with an indwelling urinary catheter bag.<br><br>Findings include:<br><br>A review of the facility's policy, titled, "Quality of Life-Dignity", revised August 2006, revealed: Staff shall promote dignity and assist residents as needed by helping residents to keep urinary catheter bags covered.<br><br>On 8/13/18 at 5:40 PM, an observation revealed, Resident #25 had an indwelling urinary catheter connected to a gravity drainage bag, and there was no privacy bag covering the drainage bag.<br><br>On 8/14/18 at 11:45 AM, an observation revealed, | F 550 | Disclaimer:<br>Bedford Care Center of Hattiesburg, LLC acknowledges receipt of Statement of Deficiencies and proposes this plan of corrections to the extent that the summary of the findings is factually correct and in order to maintain compliance with applicable rules and regulations. Please accept this plan of correction as our allegation of compliance. Bedford Care Center of Hattiesburg, LLC response to this statement of deficiencies does not denote agreement with the statement of deficiencies nor does it constitute an admission that any deficiency is accurate.<br><br>F550<br><br>* On August 14, 2018, Resident # 25's urinary catheter drainage bag was changed to a fig leaf privacy drainage bag by Registered Nurse Supervisor # 2. | |

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| F 550 | Continued From page 2<br>Resident #25 was sitting in his room in his wheelchair with an indwelling urinary catheter connected to a drainage bag, and there was no dignity bag covering his drainage bag.<br><br>On 8/14/18 at 2:00 PM, an interview with Certified Nursing Assistant (CNA) #1 revealed Resident #25 does not have a dignity bag over his catheter bag. CNA #1 stated Resident #25 was not here this morning because he had an appointment. CNA #1 stated, it is a dignity issue (referring to the catheter drainage bag not covered by a privacy bag), and she will make sure she takes care of this issue.<br><br>On 8/14/18 at 2:33 PM, an interview with the Director of Nurses (DON) revealed, it is a dignity issue not to have a privacy bag covering the catheter drainage bag.<br><br>On 8/15/18 at 8:10 AM, interview with CNA #4 revealed, it is a dignity issue for the resident not to have a privacy bag covering the urinary catheter drainage bag.<br><br>Record review of the Medication Administration Record (MAR) for August 2018, revealed Foley Catheter 16 French with 10 Cubic Centimeter (CC) bulb, connected to closed drainage system for Urinary Retention.<br><br>Review of the Physician Orders revealed an order, dated 08/16/18, for a Foley Catheter 16 French with a 10 cubic centimeter (CC) bulb, connected to a closed drainage system for Urinary Retention.<br><br>Review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of August 13, | F 550 | Resident # 25 was discharged from the facility on August 20, 2018.<br><br>** Residents with urinary catheter drainage bags have the potential to be affected by this alleged deficient practice.<br><br>*** On August 14, 2018, the Resident Care Coordinators observed five (5) residents with catheter drainage bags and found that these residents had fig leaf privacy drainage bags;five of five residents were observed with drainage bags with no negative findings. Beginning on August 27, 2018, through September 11, 2018, the Staff Development Registered Nurse in-serviced licensed and certified nursing staff regarding resident's rights and dignity, including providing privacy with the fig leaf privacy drainage bag. On August 26, 2018, the Director of Nurses or the Resident Care Coordinators began auditing catheter drainage bags to ensure privacy by using fig leaf privacy drainage bags. These random audits are to be conducted nine(9) times per week for two weeks, then six (6) times per week for two weeks and then three (3) times a week for two weeks. The Director of Nurses modified the admission / re-admission check list on September 11, 2018, to include identifying residents with catheters upon admission and changing the urinary drainage bag to a fig leaf privacy drainage bag by the Registered Nurse completing the admission.<br><br>**** The findings of the audits will be | |

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| F 550 | Continued From page 3<br>2018, section H for bowel and bladder continence was coded for an indwelling catheter. The Brief Interview for Mental Status (BIMS) revealed, Resident #25 had a BIMS score of 12, which indicated moderate cognitive impairment.<br><br>Review of the facility's Record of Admission revealed Resident #25 was admitted by the facility, on 8/6/18, with a diagnosis of Urinary Retention. | F 550 | reported to the Quality Assurance Committee, monthly for three (3) months, by the Director of Nurses. The Quality Assurance committee will make recommendations as needed. | |
| F 656 SS=D | Develop/Implement Comprehensive Care Plan<br>CFR(s): 483.21(b)(1)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the | F 656 | | 10/9/18 |

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| F 656 | Continued From page 4<br>findings of the PASARR, it must indicate its rationale in the resident's medical record.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, facility policy review, and staff interview, the facility failed to follow Resident #22's comprehensive care plan related to pressure ulcers, for (1) one of 30 resident care plans reviewed.<br><br>Findings include:<br><br>Review of the facility's policy, titled, "Using the Care Plan", revised August 2006, revealed, the care plan shall be used in developing the resident's daily care routines, and will be available to staff personnel who have responsibility for providing care or services to the resident.<br><br>Review of Resident #22's Care Plan revealed the Problem for the Potential for Altered Skin Integrity, with an original date of 05/29/18, and on 06/05/18 a Deep Tissue Injury (DTI) to the right heel, and on 07/22/18, a stage three (3) to the | F 656 | F656<br><br>* Resident # 22 was discharged on September 6, 2018, prior to the facility receiving the statement of deficiencies.<br><br>** Residents with Care Plans related to pressure ulcers and potential altered skin integrity may be affected by this alleged deficient practice.<br><br>*** Beginning August 27, 2018, through September 11, 2018, the Staff Development Registered Nurse conducted in-services related to following care plans to promote skin integrity. On September 14, 2018, the Medications Administration Records (MAR) for residents with pressure ulcers and potential for altered skin integrity have been updated, by the Order Entry Nurse, | |

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| F 656 | Continued From page 5<br>right heel. Interventions, dated 05/29/18, included pressure relieving mattress to the bed, and cushion to the chair, observe for new onset of skin complications/breakdown, weekly body audits, and provide treatment to the stage three (3) pressure injury to the right heel as ordered until healed. On 06/07/18, an intervention to apply heel protectors to bilateral feet and float heels while in bed was added. Further review of the Care Plan revealed the Problem for Requiring Assist with ADLs (Activities of Daily Living) due to left sided hemiplegia/involuntary tremors dated 05/29/18. The Interventions, dated 05/29/18, included extensive assist x 2 (times two) with bed mobility. Interventions, dated 08/09/18, included extensive assist x 1 (times one) with bathing, wheel chair mobility, and hygiene, and on 08/15/18, extensive assist x 2 (times two) with toileting.<br><br>Review of Resident #22's Admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/04/18, revealed there were no pressure ulcers present, and Resident #22 was at risk for developing pressure ulcers.<br><br>Review of Resident #22's 60 Day Scheduled Assessment MDS, with an ARD of 07/24/18, revealed the presence of a stage three (3) pressure ulcer<br><br>On 8/14/18 at 12:05 PM, an observation revealed Registered Nurse (RN) #2, assisted by Certified Nursing Assistant (CNA) #5, provided wound care to Resident #22's right heel. Resident #22's right heel was noted to be pink with no drainage.<br><br>On 8/15/18 at 12:15 PM, an interview with Registered Nurse (RN) #1 revealed she would | F 656 | to include documentation for heel protectors, flotation of heels and use of wedges. Beginning on September 12, 2018, the electronic health record for Certified Nursing Assistants' required documentation was modified by the facility's information technology contractor, to include mattress to bed, cushion to chair and new onset of skin complication or breakdown. Beginning on September 14, 2018, the Director of Nurses or the Resident Care Coordinators shall review the skin hygiene body check report for ten (10) residents per week for two weeks, then five (5) residents per week for two weeks and then three (3) residents per week for two weeks, to ensure that the comprehensive care plan is followed and that documentation is provided.<br><br>**** The findings of the audits will be reported to the Quality Assurance Committee, monthly for three (3) months, by the Director of Nurses. The Quality Assurance committee will make recommendations as needed. | |

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| F 656 | Continued From page 6<br>expect staff to follow the resident's care plan.<br><br>A review of the Admission Record revealed, Resident #22 was admitted by the facility, on 5/28/18, with a diagnosis of Cerebral Infarction.<br><br>Review of Resident #22's Admission MDS, with an ARD of 06/04/18, revealed a Basic Interview for Mental Status (BIMS) score was 5, which indicated severe cognitive impairment. | F 656 | | |
| F 686 SS=D | Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)<br><br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and<br>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, record review, and facility policy review, the facility failed to prevent pressure ulcer development for (1) one of (6) six pressure ulcer observations, for Resident #22.<br><br>Findings include:<br><br>A review of the facility's policy titled, "Pressure | F 686 | F686<br><br>* Resident # 22 discharged from the facility on September 6, 2018, prior to the facility receiving the statement of deficiencies.<br><br>** Residents with potential for altered skin integrity may be affected by this alleged | 10/9/18 |

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| F 686 | Continued From page 7<br>Ulcer/Skin Breakdown-Clinical Protocol", revised April 2018, revealed the staff and practitioner will examine the skin of newly admitted residents for evidence of existing pressure ulcers or other skin conditions.<br><br>On 8/14/18 at 12:05 PM, an observation revealed Registered Nurse (RN) #2, assisted by Certified Nursing Assistant (CNA) #5, provided wound care to Resident #22's right heel. Resident #22's right heel was noted to be pink with no drainage.<br><br>Record review of the most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 8/7/18, revealed a pressure ulcer stage three (3) coded in section M of the MDS. Review of the Admission MDS, with an ARD of 6/4/18, revealed section M was coded to show no pressure ulcers present.<br><br>Review of the August 2018 Treatment Administration Record (TAR) revealed a treatment, with a start date of 07/22/18, for a stage three (3) pressure injury to the right heel, and to cleanse the pressure injury with Normal Saline (NS), pat dry, and apply Promogran to the wound bed once every three (3) days. Apply skin prep to the peri-wound area, and cover with a border foam. Further review the TAR revealed the treatment changed, on 08/14/18, to cover the stage three (3) pressure injury to the right heel with a border foam dressing, and change every three (3) days and as needed (prn).<br><br>Review of the August 2018 Physician Orders revealed an order, dated 08/14/18, to cover the stage three (3) pressure injury to the right heel with a border foam dressing, and change every three (3) days and as needed (prn). Further | F 686 | deficient practice.<br><br>*** Beginning on August 27, 2018, through September 11, 2018, the Staff Development Registered Nurse conducted in-services with Licensed Nurse and Certified Nursing Assistants, related to promoting skin integrity. On September 14, 2018, the Medications Administration Records (MAR)for residents with pressure ulcers and potential for altered skin integrity have been updated to include documentation for heel protectors, flotation of heels and use of wedges, by the Order Entry Nurse. On September 12, 2018, the electronic health record for Certified Nursing Assistants' required documentation was modified by the facility's information technology contractor, to include mattress to bed, cushion to chair and new onset of skin complication or breakdown. Beginning on September 14, 2018, the Director of Nurses or the Resident Care Coordinators shall review the skin hygiene body check report for ten (10) residents per week for two weeks, then five (5) residents for per week two weeks and then three (3) residents per week for two weeks, to ensure the comprehensive care plan is being followed and documentation is being provided. Beginning on September 17, 2018, to ensure the accuracy of the initial admission or readmission body audit, the Resident Care Coordinator or the Registered Nurse Supervisor shall conduct additional body audits of fifty (50)% of residents admitted or readmitted each week for two weeks, | |

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| F 686 | Continued From page 8<br>review of the Physician's Orders revealed an order, dated 08/14/18, to discontinue the pressure injury treatment to the right heel to cleanse the injury with NS, pat dry and apply Promogram<br><br>On 8/15/18 at 11:15 AM, an interview, with the Director of Nurses (DON), revealed Resident #22 was admitted, and roughly about three (3) days later had a Deep Tissue Injury (DTI) that later opened. The DON stated everybody (referring to the nursing staff) knows the standard to float heels, and to turn residents while in bed. She also stated, if the area had been identified earlier on admission, for example, the staff would have been able to treat it earlier.<br><br>A review of the facility's Record of Admission revealed Resident #22 was admitted by the facility, on 5/28/18.<br><br>Review of the most recent MDS, with an ARD of 8/7/18, revealed a Brief Interview of Mental Status (BIMS) score of 8, indicating a moderately impaired cognitive status. | F 686 | then thirty (30)% of residents admitted or readmitted each week for two weeks and then ten (10)% of residents admitted or readmitted each week for two weeks.<br><br>**** The findings of the audits will be reported to the Quality Assurance Committee, monthly for three (3) months, by the Director of Nurses. The Quality Assurance committee will make recommendations as needed. | |
| F 880 SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program. | F 880 | | 10/9/18 |

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| F 880 | Continued From page 9<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and | F 880 | | |

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| (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 |
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| F 880 | Continued From page 10<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, record review and facility policy review, the facility failed to dispense ice in a sanitary manner on the South Wing to prevent the possible spread of infection for one (1) of three (3) wings observed.<br><br>Findings include:<br><br>Review of the facility's policy titled, "Ice Machines and Ice Storage Chests", revealed ice machines and ice storage/distribution containers will be used and maintained to assure a safe and sanitary supply of ice. Ice storage chests/containers, and ice can all become contaminated by unsanitary manipulation by employees, residents and visitors. To help prevent contamination of ice storage chests/containers or ice, staff shall follow these precautions: "Keep the ice scoop/bin in a covered container when not in use."<br><br>On 8/13/18 at 5:25 PM, an observation revealed | F 880 | F880<br><br>* On South Wing, ice is being dispensed in a sanitary manner to prevent the possible spread of infection. On August 13, 2018, the Registered Nurse Supervisor # 1 in-serviced CNA # 2 and CNA # 3 related to proper handling of ice.<br><br>** Residents who receive ice have the potential to be affected by this alleged deficient practice.<br><br>*** Beginning on August 27, 2018, through September 11, 2018, the Staff Development Registered Nurse conducted in-services with the Licensed Nurse and Certified Nursing Assistants related to proper ice distribution. On August 27, 2018, educational information was added to the staffing agency orientation manual, related to proper | |

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|---|---|---|---|
| | 255158 | A. BUILDING _____ B. WING _____ | 08/16/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| F 880 | Continued From page 11<br>Certified Nursing Assistant (CNA) #2 filled a resident's pitcher with ice from the ice chest. CNA #2 placed the ice scoop inside the ice chest and closed the top. CNA #3 came up seconds later, opened the ice chest, removed the scoop, filled a pitcher, and placed the scoop in the holder located on the side of the ice chest.<br><br>An interview, on 8/13/18 at 5:30 PM, revealed CNA #2 stated she was an agency CNA. CNA #2 stated, "I left it (referring to scoop) in there, because she (CNA #3) was coming behind me." CNA #2 initially revealed there was not a problem with leaving the ice scoop inside the ice chest, but then stated, "it could cause cross contamination."<br><br>A review of the CNA Skills Checklist for CNA #2 provided to the facility from [Name of Agency], dated 11/10/17, revealed there was no training provided to CNA #2 for Infection Control. There was no documentation provided to indicate CNA #2 had received any training on Infection Control from the facility.<br><br>An interview, on 8/13/18 at 5:35 PM, with CNA #3, revealed she was an agency CNA. CNA #3 confirmed CNA #2 left the ice scoop inside the ice chest. CNA #3 stated the ice scoop was "in the ice." CNA #3 further stated, "I took it out and put it in the holder." CNA #3 was aware it was an infection control issue.<br><br>An interview, on 08/16/18 at 10:15 AM, with the Staff Development Nurse (SDN), revealed leaving the ice scoop in the ice was an infection control issue. The SDN revealed the facility uses three (3) different agencies to provide additional staffing for their facility. One of the agencies was their "sister facility." The SDN revealed she had | F 880 | dispensing of ice, by the Staff Development Registered Nurse. Beginning on August 26, 2018, the Director of Nurses or the Resident Care Coordinators shall observe dispensing of ice nine (9) times per week for two weeks, then six (6) times per week for two weeks then three (3) times per week for two weeks to ensure safe and sanitary dispensing of ice on all wings. These observations will be recorded on an audit tool by the Director of Nurses or the Resident Care Coordinators.<br><br>**** The findings of the audits will be reported to the Quality Assurance Committee, monthly for three (3) months, by the Director of Nurses. The Quality Assurance committee will make recommendations as needed. | |

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| F 880 | Continued From page 12<br>no training records on Infection Control for CNA #2. The SDN stated she has been putting together a program for training agency CNAs over the past few months.<br><br>Interview, on 8/16/18 at 10:50 AM, with the Director of Nursing (DON), revealed the facility implemented training packets for agency staff about three (3) months ago. The DON stated the SDN had been "trying to chase the agency nurse aides down" to get the training packets completed. | F 880 | | |

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| | 255158 | A. BUILDING **02 - BUILDING 02**<br>B. WING _____ | **08/14/2018** |

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| **BEDFORD CARE CENTER OF HATTIES** | **#10 MEDICAL BOULEVARD**<br>**HATTIESBURG, MS 39401** |

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| K 000 | INITIAL COMMENTS<br><br>42 CFR 483.70(a)<br><br>The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA).<br><br>There were no LSC deficiencies cited during this survey. | K 000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 09/10/2018

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.

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| E 000 | Initial Comments<br><br>Survey conducted on 8/14/18 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements.<br><br>No deficiencies were identified. | E 000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 09/10/2018

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