

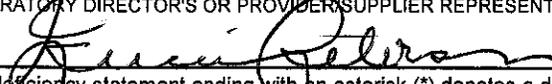
ORIGINAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A073	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/22/2015
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NAME OF PROVIDER OR SUPPLIER SANFORD CHAMBERLAIN CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 300 S BYRON BLVD CHAMBERLAIN, SD 57325
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F 000	INITIAL COMMENTS Surveyor: 34030 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 10/20/15 through 10/22/15. Sanford Chamberlain Care Center was found not in compliance with the following requirements: F226, F281, and F323.	F 000		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Surveyor: 35625 Based on record review, interview, and policy review, the provider failed to thoroughly investigate and report: *An injury after a fall, verbal abuse to a resident by a staff member, bruises of unknown origin, and altercations between residents to the South Dakota Department of Health (SD DOH) for five of five (1, 5, 7, 8, and 13) residents. *A fracture for one of one sampled resident (6) who had an incident with her wheelchair. Findings include: 1. Review of the fall event report for resident 8 revealed: *On 9/30/15 he had an unwitnessed fall in his room. *He sustained an approximately two inch	F 226	F226 -DON, Social Worker, LTC Administrator, Quality Manager, and Medical Director reviewed reporting policy. All facility staff involved in LTC were educated on Nov 4th, Nov 6th, Nov 9th & Nov 10th. Remaining staff to be educated one on one, over phone or face to face by 11/18/15 or next scheduled shift. Education on mistreatment, neglect & misappropriation of resident property to include hiring & screening of employees, training r/t abuse prohibition practices, prevention, identification, investigation, protection and reporting. Hypothetical resident scenarios were used as teaching examples. (cont next page)	11/18/15 No employee will work a shift until education is complete EP 11-19-15 DON completed follow up 1-1 staff education re. incident reporting on 11-11-15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE CEO	(X6) DATE 11-11-15
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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 226	<p>Continued From page 1</p> <p>laceration (cut) with blood loss and a bump to the back of the head.</p> <p>*Vital signs (blood pressure, pulse, and temperature) and neurological checks (level of alertness, facial movement, hand grasps, eye position, and speech) were completed following the fall.</p> <p>*The resident was able to say he was experiencing mild pain and rated it at a 1 on a 0-10 scale (0 meaning no pain and 10 being the worst pain).</p> <p>*Emergency room (ER) staff assisted the resident off the floor of his room and transferred him to the ER for evaluation.</p> <p>Review of the nursing progress notes from 10/1/15 at 12:37 a.m. and at 5:50 a.m. for resident 8 revealed:</p> <p>*He returned from the ER with eight staples to the laceration on his head.</p> <p>*New physician orders were written in the ER for nursing home staff to follow including:</p> <p>-Wound cleansing, dressing changes, monitoring for signs and symptoms of infection, and follow-up for removal of the staples.</p> <p>Interview on 10/21/15 at 2:15 p.m. with the director of nursing (DON) regarding resident 8's fall revealed:</p> <p>*An internal investigation had not been thoroughly completed.</p> <p>*An initial and final event report was not sent to the South Dakota Department of Health (SD DOH) following the fall.</p> <p>*The DON stated the event was not reported to the SD DOH since it involved an injury to the head and did not involve a fracture.</p> <p>Interview on 10/22/15 at 8:30 a.m. with the DON</p>	F 226	<p>F 226 (cont) DON or designee will monitor all reportable events for 3 months and report to QA committee. QA Committee will define thereafter.</p> <p>→ weekly x 1 month, monthly x 3 months, then quarterly until QA determines audit can be discontinued, QA committee meets monthly.</p> <p>EP 11-19-15</p>	<p>including the need to report to the SD DOH, thoroughness of the investigation, timeliness of reporting to the SD DOH.</p> <p>EP 11-19-15</p>	

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F 226	<p>Continued From page 2</p> <p>regarding reporting of serious injury events to the SD DOH revealed:</p> <p>*A nurse or certified nursing assistant would start an internal investigation report, and it would be routed to the appropriate personnel.</p> <p>*The social worker would begin an event report to the SD DOH, and the DON would assist as needed.</p> <p>*The algorithm (a set of instructions) on the SD DOH website was used in determining if an event should have been reported.</p> <p>*The fall from 9/30/15 was reviewed by the DON and social worker, and it was determined no report was to be made to the SD DOH for the following reasons:</p> <p>-The fall did not involve a fracture.</p> <p>-The fall did not involve severe pain.</p> <p>Interview on 10/22/15 at 11:05 a.m. with the social worker regarding the reporting of resident 8's 9/30/15 fall to the SD DOH revealed:</p> <p>*The fall required the resident be evaluated and treated in the emergency room.</p> <p>*The fall could be viewed as a serious injury requiring a report to the SD DOH.</p> <p>Review of the provider's April 2012 Fall Prevention and Follow-up Reporting Policy revealed, "A report will be sent to the State Department of Health if a resident has a fracture or serious injury from the fall."</p> <p>Review of the provider's May 2013 Abuse: Reporting/Response Policy revealed, "The Social Worker or DON will complete a nursing facility event reporting for each alleged abuse or neglect including injury of unknown origin incident and notify the SD DOH and the local Ombudsman within the regulated 24 hours of the incident..."</p>	F 226			

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F 226	<p>Continued From page 3</p> <p>Surveyor: 32332</p> <p>2. Review of resident 6's 10/5/15 physical harm/injury report revealed: *Interviews with certified nursing assistants (CNA) D and F regarding the events on 10/4/15-10/5/15 prior to x-ray results of a leg fracture. *The interviews indicated: *Resident 6 had a blanket wrapped around her and under the wheel of her wheelchair. *The CNAs pulled the blanket out from under the wheelchair. *The CNAs later placed her in bed using a mechanical lift. *Resident 6 complained of foot pain and reported: -Her foot got caught in the strap of the lift during the transfer. -Her "foot got caught on the pedal."</p> <p>The DON interviewed the RN B, nurse on duty the night of the injury. The event report had not indicated if she had asked the staff if the wheelchair pedals had been used at the time the blanket had become caught in the wheelchair.</p> <p>3. Review of resident 7's 3/25/15 resident-to-resident altercation (struck another resident) event report revealed: *There was no initial report. *There was no date on the report indicating when the Department of Health had been notified of the event. *The 4/2/15 final (5-day) report of an allegation of verbally inappropriate comments from a staff member toward the resident. *The findings revealed the investigation had been completed, and the was no injury or negative outcome to the resident.</p>	F 226			

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F 226	<p>Continued From page 4</p> <p>*The report had not contained: -Who had been interviewed. -What had caused the investigator to come to the conclusion the report not substantiated (proven).</p> <p>Interview on 10/21/15 at 11:20 a.m. with the social worker revealed: *She had done the initial report but was not sure where it was. *She had not been sure who had been interviewed to determine no injury had been caused to the resident.</p> <p>4. Review of an undated event occurrence combined Initial and Final report indicated it was reported 5/4/15 that resident 7 had struck resident 1 on 5/1/15. There had been no documentation regarding: *What the investigation had included. *Who might have been interviewed as part of the investigation. *Any events that might have caused the resident to strike another resident.</p> <p>Interview on 10/22/15 at 11:20 a.m. with the social worker revealed there was no more to report regarding the above incident.</p> <p>5. Review of an 8/31/15 event report with allegation of physical harm related to a bruise on resident 13 revealed: *The resident had a bruise of unknown origin (cause). *The bruise had been investigated on 8/31/15. *The resident was unable to tell staff how the bruise had occurred. *The resident had been observed at times at night with behaviors. *During those times he might have hit his arm on</p>	F 226			

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F 226	<p>Continued From page 5 a table, chair, or bed. *There were no documented interviews with the staff. *There were no specific dates or times of those behaviors.</p> <p>Interview on 10/22/15 at 11:00 a.m. with the director of nursing revealed: *She had seen resident 13 pound on furniture in the past. *She had been told by the Department of Health that she had provided too much information with previous reports in the past. *She had made another report after an interview with this surveyor on 10/21/15 at 5:00 p.m. that had indicated she had seen the resident pound on furniture.</p> <p>6. Review of the provider's July 2011 Abuse Investigation policy revealed: *It was done to provide a manner by which alleged (claimed) abuse violations would have been investigated. *The social services designee and/or director of nursing would investigate alleged violations. *They would interview any resident, visitor, and staff involved. Depending on the circumstances coworkers and other residents would be interviewed. *That investigative report would be faxed to the State Department of Health within five days of the original report.</p> <p>Review of the provider's June 2011 Event Reporting Policy and Procedure revealed: *The purpose was to provide a tracking device for the provider so that care being given could be evaluated against the established standards of practice and corrective measures could be taken</p>	F 226			

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F 226	Continued From page 6 to improve quality of care. *The supervisor/department head or designee was to have recorded incidents as quickly as possible, not exceeding twenty-four hours. *The supervisor/department head should have conducted initial investigations of each situation as soon as possible to assure all facts were accumulated, that the report was completed accurately and that corrective actions were taken to prevent recurrence. *The quality management/improvement committee would have completed the investigation by consulting with other involved departments.	F 226		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on record review, interview, policy review, and job description review, the provider failed to document and report concerns for one of one sampled resident (6) with pain and possible injury. Findings include: 1. Review of resident 6's medical record revealed: *A late entry recorded on 10/5/15 at 6:50 a.m. for 10/4/15 in the nursing progress notes by registered nurse (RN) B had indicated "Resident states that her leg was caught in the wheel chair on 10/4/15 during a transfer. She is now complaining of severe pain. PRN [as needed	F 281	F281 – DON, LTC Admin, & Quality Manager developed & reviewed LTC Nursing 093, Nursing Assistant & CMA Duties General Guidelines For Certified Medication Aides/Certified Nurse's Aides. An in-service was provided to all staff serving in CMA capacity on Nov 6th & 9th to provide education & review med aide policy as well as a competency exam was completed on Nov 6 & 9th. DON or designee will report QA monthly audit results on safe medication administration to QA (cont next page)	11/18/15

and monitoring of protein supplements
-EP
11-19-15

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F 281	<p>Continued From page 7</p> <p>medication] for pain has been given. Resident has rested most of the night."</p> <p>*No other entries had been documented on 10/4/15.</p> <p>*A 10/5/15 entry in the nursing progress notes at 8:58 a.m. by licensed practical nurse (LPN) C indicated the resident had shown a recent increase in left leg pain. The nurse had notified the physician's assistant on call, and an appointment was made for her to be seen.</p> <p>*A 10/5/15 entry in the nursing progress notes at 12:32 p.m. by LPN C indicated the x-ray report had confirmed a fracture to the left tibia and fibula (lower bones of leg).</p> <p>Review of 10/8/15 investigation statements of the possible events that could have led to the injury revealed on the night before the leg fracture was noted certified nursing assistant (CNA) D:</p> <p>*Documented resident 6 had been restless and calling out most of the night of 10/4/15 and 10/5/15.</p> <p>*CNAs D and E had placed her in a wheelchair and brought her to the dining room. (The exact time was unknown, however interviews had concluded the hour was around 2:30 a.m.).</p> <p>*She remained restless and had been pushing her wheelchair away from the desk.</p> <p>*Documented resident 6 had a blanket caught under the wheel of her wheelchair.</p> <p>*Pulled the blanket up and lifted the chair off of it.</p> <p>*Placed the resident in bed later, and the resident stated her foot got caught in the strap of the lift.</p> <p>*Pulled her sock off and noticed some bruising on the foot.</p> <p>*Notified the nurse of the above events, and the "Nurse looked at foot also."</p> <p>Interview on 10/21/15 at 10:55 a.m. with RN B</p>	F 281	<p>F281 (Cont) - Committee for 3 months. QA Committee will define thereafter.</p> <p><i>weekly x 1 m. then monthly x 3m then quarterly until QA determines the audits can be discontinued.</i></p> <p>All RN/LPN were educated on Nursing Report Procedure on Nov 6th, Nov 9th, Nov 10th and Nov 12th. DON or designee will monitor Nursing Report Procedure and report to QA monthly for 3 months, with QA Committee defining thereafter.</p> <p><i>CP</i> 11-19-15</p>	

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F 281	<p>Continued From page 8 revealed:</p> <ul style="list-style-type: none"> *He had not been aware something had happened to resident 6. *The CNAs had told him the residents leg had not been caught in the lift strap during the transfer. *He had looked at her foot at that time, but had not noticed any bruising. *He had not found anything unusual about her. *He had not documented the above concerns. *He stated the resident often: <ul style="list-style-type: none"> -Called out at night. -Reported pain symptoms. -Reported being injured during routine care from the direct care staff. *Her behaviors on that night had been her usual behaviors. *He didn't find anything unusual about her. *He had given her lorazepam (medication for anxiety) for her restlessness with some relief. *He had not reported any of the above concerns to the oncoming nurse. <p>Interview on 10/21/15 at 1:45 p.m. with LPN C revealed:</p> <ul style="list-style-type: none"> *She came on duty the morning of 10/5/15. *Nothing new for resident 6 had been reported to her from RN B. *Resident 6 had complained of pain during her shift but had been unable to tell her where the pain was. *She reported the pain to RN B when he returned to work that evening. *RN B told her he had forgotten to report to her the resident had gotten her foot caught in the wheelchair. <p>Interview on 10/21/15 at 1:30 p.m. with the director of nursing revealed:</p> <ul style="list-style-type: none"> *She was aware RN B had not documented on 	F 281			

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F 281	<p>Continued From page 9</p> <p>resident 6 on 10/4/15 at the time of her restless behaviors.</p> <p>*She was aware RN B had not reported any concerns regarding resident 6 to the oncoming nurse on the following morning.</p> <p>*She had already counseled RN B regarding the importance of documentation and reporting off to the oncoming shift.</p> <p>Review of the provider's 5/25/12 charge nurse job requirements revealed the charge nurse was to have:</p> <p>*Performed ongoing assessments of residents with complete and appropriate documentation.</p> <p>*Provided pertinent, organized, and concise shift-to-shift report.</p> <p>Review of the provider's March 2012 Nursing Report policy revealed:</p> <p>*Report was to have been completed at the change of shift without exception by the charge nurse of each household.</p> <p>*The nurse was to have reported:</p> <ul style="list-style-type: none"> -The condition of each resident. -Any condition change. -Any incidents, falls, wounds, status of residents, orders to have been followed. -The last dose of any PRN medication administered and the effectiveness of the medication given. <p>Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 6th Ed., St. Louis, Mo., 2005, p. 481, "High-quality documentation and reporting are necessary to enhance efficient, individualized client care. Quality documentation and reporting have five important characteristics: they are factual, accurate, complete, current, and organized.</p>	F 281			

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F 281	Continued From page 10 Surveyor: 34030 Surveyor: 36413 2. Observation on 10/20/15 at 4:22 p.m. revealed certified medication aide (CMA) E was preparing to give resident 14 his Arginaid (protein supplement). At that time: *She poured Arginaid into a small plastic cup. *When asked about how much Arginaid was ordered, she poured it into a larger glass without measuring. *She stated the resident should have received 6-8 ounces of Arginaid. *Review of the most current physician's order revealed he was to have received 60 cubic centimeters of Arginaid twice daily. That would have equaled 2 ounces. *CMA E did not know how to measure the Arginaid. Interview at that time with CMA E confirmed she was not aware Arginaid should have been measured.	F 281			
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 323	F323 - Dietician created policy on safe meal service at LTC. Cook A! Staff will be educated on policy during meeting on 11/11/15. Dietary manager or designee will report this to QA monthly x3 months. QA committee will define thereafter. -o	-cp 11.19.15 11/18/15	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A073	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/22/2015
NAME OF PROVIDER OR SUPPLIER SANFORD CHAMBERLAIN CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 S BYRON BLVD CHAMBERLAIN, SD 57325		
(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 323	<p>Continued From page 11</p> <p>by: Surveyor: 34030</p> <p>Based on observation and interview, the provider failed to ensure residents' safety by leaving the steam table turned on between breakfast and lunch service in one of two residents' dining areas (Mueller). Findings include:</p> <p>1. Observation on 10/20/15 at 10:30 a.m. revealed the steam table in the Mueller wing dining area was hot to the touch and was accessible to residents. The controls were turned on high. Residents were in the area at that time.</p> <p>Interview on 10/20/15 at 10:35 a.m. with cook A regarding the steam table revealed: *She kept it on between breakfast and lunch rather than turn it off. *She was unsure if she should have turned it off between meals. *When asked about the policy she stated she would check with her supervisor and "probably the supervisor told me not to" (keep the warming table on). *She was unaware the hot steam table could pose a safety risk to the residents.</p> <p>Interview on 10/21/15 at 3:00 p.m. with the dietary manager and the registered dietician revealed they agreed the steam table should not have been left on between meals. There was no specific policy regarding that.</p>	F 323			

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

ORIGINAL

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A073	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2015
NAME OF PROVIDER OR SUPPLIER SANFORD CHAMBERLAIN CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 S BYRON BLVD CHAMBERLAIN, SD 57325		
(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	<p>INITIAL COMMENTS</p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 new health care occupancy) was conducted on 10/20/15. Sanford Chamberlain Care Center was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for new health care occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000			

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

TITLE

(X6) DATE



CEO

11-11-15

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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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10606	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/22/2015
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NAME OF PROVIDER OR SUPPLIER SANFORD CHAMBERLAIN CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 300 S BYRON BLVD CHAMBERLAIN, SD 57325
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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) COMPLETE DATE
S 000	<p>Compliance/Noncompliance Statement</p> <p>Surveyor: 34030 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 10/20/15 through 10/22/15. Sanford Chamberlain Care Center was found in compliance.</p>	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Russell Peterson* TITLE **CEO** (X6) DATE **11-11-15**

STATE FORM 6899 H5BY11 If continuation sheet 1 of 1