<table>
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<tr>
<th>(X4) ID PREPFX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>F 000</th>
<th>PROVIDER'S PLAN OF CORRECTION (SUCH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 610 SS=0</td>
<td>Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)</td>
<td></td>
<td>06/29/2018</td>
</tr>
<tr>
<td></td>
<td>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must.</td>
<td></td>
<td>1. Corrective Action for Resident 65 was completed on 05/31/18 as evidenced by the completed investigation of the bruise of unknown origin. Investigation concluded that injury was the result of incident at off-site location. No additional actions were required beyond continued monitoring of the bruise. Medical Records Staff B and CNA A were educated the proper steps to report a bruise of unknown origin.</td>
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<tr>
<td></td>
<td>§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.</td>
<td></td>
<td>2. All current residents were identified for potential to be affected by the same deficient practice.</td>
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<td></td>
<td>§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.</td>
<td></td>
<td>3. All active nursing staff was identified for and participated in an in-service on 6/21/18 for possible abuse and reporting requirements as identified in our Abuse, Neglect and Exploitation policy dated 9/15/17. All active nursing staff will be required to complete the training prior to 06/29/2018.</td>
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<td></td>
<td>§483.12(c)(4) Report the results of all investigations to the administrator or his/her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:</td>
<td></td>
<td>4. The Director of Nursing Services or Designee will conduct a CNA Skin Observation Audit starting on 06/25/2018 at a frequency of two (2) times weekly for eight weeks and one (1) time per week for each subsequent week until such time as the QAPI Committee changes the frequency or continuation of the audit process. Audit documentation will be provided to the QAPI Committee by the DON or designee on a monthly basis for evaluation and implementation of alternative interventions are completed, should it be deemed necessary. The Director of Education provided the in-service training. Audits will be conducted in the resident rooms while care is provided. Audits will be on random hallways on random shifts to monitor several CNA staff. - KH 06/29/2018</td>
</tr>
<tr>
<td></td>
<td>Surveyor: 40053 Based on observation, record review, interview, and policy review, the provider failed to ensure one of one sampled resident (65) who had a bruise of unknown origin was thoroughly investigated. Findings include:</td>
<td></td>
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</table>

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.

Kaleb C. Hight
Administrator
06/22/2018
F 610 Continued From page 1

1. Review of resident 65's medical record revealed he:
   * Was admitted to the facility on 6/1/17.
   * Had a Brief Interview for Mental Status assessment score of 3 indicating severe cognitive impairment.
   * Had diagnoses of:
     - Atrial Fibrillation.
     - Hypertension.
     - Diabetes.
     - Depression.
     - Dementia/Cognitive loss.

   Observation on 5/30/18 at 9:31 a.m. with certified nursing assistant (CNA) A while she performed personal care on resident 65 revealed:
   * She performed hand hygiene and placed gloves on her hands.
   * She assisted resident to stand.
   * She removed his pants and brief.
   * There was a purple bruised area on the back of his upper right thigh approximately the size of a lemon.
   * She used disposable wipes to clean the resident.
   * She changed gloves.
   * She placed a clean brief and trousers on him.
   * She removed her gloves and performed hand hygiene.

Interview on 5/30/18 at 9:31 a.m. with CNA A after concluding the above personal care revealed she:
   * Had not noticed the bruise on his back right upper thigh.
   * Stated, "He's on a blood thinner and bruises easily."
   * Would let the nurse working the floor know about the bruise.

Interview on 5/31/18 at 1:45 p.m. with the Director
**F 610** Continued From page 2
of Nursing (DON) regarding the above revealed:
*She was unaware of the bruise.*
*She would investigate and get back to me.*

Interview on 5/31/18 at 3:45 p.m. with the DON regarding the bruise for resident 65 revealed:
*She stated "The resident is on Coumadin and does easily bruise."*
*He went with medical records staff B to a hospital appointment on 5/29/18.*
*Medical records staff B revealed to the DON:*  
-While at his appointment, he needed to use the restroom.  
*The resident was assisted by hospital staff.*
*There was no riser available for the toilet seat.*
**"The resident went down hard,"
*She did not realize medical records staff B needed to report the incident.*
*She felt it was the hospital's responsibility to report the incident to the facility.*
*She would be calling the hospital where the incident occurred.*
*She educated medical records staff B of the need to pass on information.*
*She also would have expected CNA A to have reported the bruise to the floor RN earlier in the day.*

Review of the provider's 9/15/17 Abuse, Neglect, and Exploitation policy revealed:
**"Identification of Abuse, Neglect, and Exploitation-the facility will consider factors indicating possible abuse, neglect, and/or exploitation of residents, including, but not limited to, the following possible indicators":**
-Resident, staff, or family report of abuse.
-Physical marks such as bruises or patterned appearances.
-Physical injury of resident, of unknown source.
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<td>F 610</td>
<td>Continued From page 3</td>
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<td></td>
<td>-Verbal abuse of a resident overheard.</td>
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<td>-Physical abuse of a resident observed.</td>
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<td>&quot;...Anyone in the facility can report suspected abuse to the abuse agency hotline. When abuse, neglect, or exploitation is suspected, the Licensed Nurse should&quot;:</td>
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<td>-Respond to the needs of the resident and protect them from further incident.</td>
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<td>-Notify the DON and Administrator (document).</td>
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<td>-Initiate an investigation immediately.</td>
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<td>-Notify attending physician, resident's family/legal representative, and Medical Director.</td>
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<td>-Obtain witness statements.</td>
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<td>-Contact the State Agency and the local Ombudsman office to report the alleged abuse.</td>
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Review of the provider's July 2017 Accidents and Incidents-Investigating and Reporting-ULC (United Living Community) policy revealed:

"All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the Administrator."

"The nurse supervisor/charge nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident."

"The nurse supervisor/charge nurse and/or the department director or supervisor shall complete a "Report of Incident/Accident" form and submit the original to the DON within 24 hours of the incident or accident."

"The DON shall ensure that the administrator receives a copy of the "Report of Incident/Accident" form for each occurrence."

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<td>F 880</td>
<td>Infection Prevention &amp; Control</td>
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<tr>
<td>SS=E</td>
<td>CFR(s): 483.80(e)(1)(2)(4)(e)(f)</td>
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F 880 Continued From page 4

§483.80 Infection Control

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.

§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§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;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported,
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections,
(iv) When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation,

F 880 Infection Prevention & Control CFR(§): 483.80(a)(1)(2)(4)(e)(f)

1. Corrective Action for Resident 35, 62, and 87 could not be accomplished due to one time treatments were completed by RN C on 05/31/2018. RN C’s employment was terminated on 05/31/2018, therefore all residents receiving treatment from RN C were no longer at increased risk of infection.

2. All current residents were identified for potential to be affected by the same deficient practice while receiving treatment. All treatments are provided by nurses, therefore all nurses were identified for additional training.

3. All active nurses were identified for and participated in an inservice on 02/20/2018 for procedures: Wound Change, Hand Hygiene, Guidelines for preventing Intravenous Catheter-Related Infections, Guidelines for Preventing Urinary Tract Infections, and Personal Protective Equipment.

Training required completion of competencies for use of proper PPE, maintaining a sterile field during dressing change and hand hygiene. All active nurse staff will be required to complete the training prior to 09/29/2018.

4. The Director of Nursing Services or Designee will conduct a Wound Change/Treatment Audit starting on 06/29/2018 at a frequency of two (2) times weekly for eight weeks and one (1) time per week for each subsequent week until such time as the QAPI Committee changes the frequency or continuation of the audit process. Audit documentation will be provided to the QAPI Committee by the DON or designee on a monthly basis for evaluation and implementation of alternative interventions will be completed, should it be deemed necessary.

The Director of Nursing Services and Director of Education provided the inservice training. Audits will be conducted in the resident rooms while treatments are provided. Audits will be on random hallways on random shifts in order to monitor several different nurses performing treatments. - KH 06/29/2018
### F 880

Continued From page 5

- depending upon the infectious agent or organism involved, and
- (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
- (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
- (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:

Surveyor: 29162

Based on observation, interview, and policy review, the provider failed to ensure three of four randomly observed resident (35, 62, and 67) treatments by one of two registered nurses (RN) (C) were completed using proper infection control practices for treatments. Findings include:

1. Observation on 5/30/18 at 2:30 p.m. of RN C while she completed a treatment for resident 35's right foot revealed she:

   *Carried supplies in the side pocket of her*
# UNITED LIVING COMMUNITY

**NAME OF PROVIDER OR SUPPLIER:**

**STREET ADDRESS, CITY, STATE, ZIP CODE:**

405 FIRST AVE
BROOKINGS, SD 57006

**DATE SURVEY COMPLETED:** 05/31/2018

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<td>F 880</td>
<td>Continued From page 6 uniform pants. *Those supplies included gloves, a roll of tape, unwrapped gauze, and scissors. *Laid the supplies directly onto the foot rest of the resident's chair. *Removed her gloves and put on clean gloves four times without sanitizing her hands. *Exited the resident's room without washing or sanitizing her hands. 2. Observation on 5/30/18 at 2:40 p.m. of RN C while she completed a treatment for resident 67 revealed she: *Did not wash or sanitize her hands when she entered the room. *Donned gloves. *Laid supplies she carried in her pocket directly onto the resident's bed spread. *Some of those supplies were not individually wrapped. *Reached into her pocket to retrieve her walkie talkie with unclean hands. *Put that same walkie talkie back into her pocket without cleaning it. *During the treatment she removed her gloves and donned clean gloves four times without sanitizing her hands. *Left the resident's room with out washing or sanitizing her hands. 3. Observation on 5/30/18 at 2:55 p.m. of RN C while she completed three treatments for resident 62 revealed she: *Did not wash or sanitize her hands when she entered the room and before she donned gloves. *Completed three different treatments for the resident. *Did not wash or sanitize her hands between any of those treatments.</td>
<td>F 880</td>
<td>CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY</td>
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Continued From page 7

*Grabbed the garbage can with a gloved hand and continued to use that hand to complete a treatment without changing that glove.
*Dropped a closed package of skin cleaner onto the floor.
*Picked that package of skin cleaner up from the floor with her gloved hand.
*Used that same skin cleaner to clean a wound without changing that glove.
*Did not change gloves between the end of the second and start of the third treatment
*Did not sanitize her hands between any glove changes.
*Did not complete handwashing before exiting the room.

4. Interview on 5/30/18 at 3:25 p.m. with RN C regarding the above three dressing changes revealed she had completed them per her usual practice. She had been unaware she had not used correct infection control practices.

Interview on 5/31/18 at 4:00 p.m. with the director of nursing revealed she agreed:
*Handwashing should have been completed:
-Between all glove changes.
-Whenever gloves became soiled.
*RN C should not have:
-Carried supplies in her pocket.
-Laid supplies down without a clean barrier.
-Reached into her pocket with soiled gloves on to use the walkie talkie.
-Returned the uncleaned walkie talkie to her pocket with the same gloves on.
-Picked up the garbage can with her gloved hands without changing gloves afterward.
-Used the skin cleaner from the floor.
-Changed gloves without sanitizing her hands between removing the soiled gloves and donning...
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<tr>
<td>F 880</td>
<td>Continued From page 8 the clean gloves.</td>
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<td></td>
<td>Review of the provider's 1/29/16 Hand Hygiene policy revealed hands were to have been washed after touching a resident or handling his/her belongings.</td>
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<td>Review of the provider's 8/24/16 Wound Change policy revealed:</td>
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<td>*The policy included singular and multiple wound dressing changes.</td>
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<td>*The procedure had been to wash hands or use had sanitizer on entering the residents room.</td>
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<td>*The RN's hands were to have been:</td>
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<td>-Sanitized with hand gel or washed after removing gloves.</td>
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<td>-Washed at the end of the last treatment.</td>
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENmRS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLA
IDENTIFICATION NUMBER: 435079

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(X3) DATE SURVEY COMPLETED
05/31/2018

NAME OF PROVIDER OR SUPPLIER
UNITED LIVING COMMUNITY

STREET ADDRESS, CITY, STATE, ZIP CODE
405 FIRST AVE
BROOKINGS, SD 67006

(S) ID
PREFIX
TAG
E 000

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LEC IDENTIFYING INFORMATION)
Initial Comments

Surveyor: 29162
An initial health survey for compliance with 42
CFR 482 Subpart B, Subsection 483.73,
Emergency Preparedness requirements for
Long-Term Care Facilities, was conducted from
5/30/18 through 5/31/18. United Living
Community was found in compliance.

E 000

ID
PREFIX
TAG

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY)

(S) COMPLETION DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Kaleb C. Hight

TITLE
Administrator

(XS) DATE
06/22/2018

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. A deficiency statement on an approved plan of correction is requisite to continued
program participation.
**SUMMARY STATEMENT OF DEFICIENCIES**

- **K 000 INITIAL COMMENTS**
  - Surveyor: 14180
  - A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 5/30/18. United Living Community was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.
  - The building will meet the requirements of the 2012 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 5/30/18.
  - Please mark an "F" in the completion date column for the deficiency identified as meeting the FSES to indicate the provider's commitment to continued compliance with the fire safety standards.

- **K 311**
  - Vertical Openings - Enclosure
  - CFR(s): NFPA 101
  - Vertical Openings - Enclosure
  - 2012 EXISTING
  - Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6
  - If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box.
  - This **REQUIREMENT** is not met as evidenced by:
  - Surveyor: 14180
  - Based on observation and document review, the
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<tr>
<td>K 311</td>
<td>Continued From page 1 provider failed to maintain the one hour fire resistive rating of vertical openings in two randomly observed areas (elevator shaft on each level for the first floor and basement). Findings include: 1. Observation at 11:00 a.m. on 5/30/18 revealed the elevator separation doors on the first floor and in the basement were hollow metal doors with wire glass vision panels. The doors did not have identification labels to indicate a fire resistive rating. That deficiency affected the service wing smoke compartment only and should not affect resident safety. Review of previous survey data revealed that condition had existed since the original construction of the building. Because the elevator was in the service smoke compartment it would only affect staff that might be in that area. The building meets the FSES. Please mark an &quot;F&quot; in the completion date column to indicate correction of the deficiencies identified in K000.</td>
<td>K 311</td>
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**South Dakota Department of Health**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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<td>A. BUILDING:</td>
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<td>B. WING:</td>
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**DATE SURVEY COMPLETED**

05/31/2018

**NAME OF PROVIDER OR SUPPLIER**

UNITED LIVING COMMUNITY

405 1ST AVE

BROOKINGS, SD 57006

**STREET ADDRESS, CITY, STATE, ZIP CODE**

**SUMMARY STATEMENT OF DEFICIENCIES**

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**Compliance/Noncompliance Statement**

Surveyor: 29162

A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 5/30/18 through 5/31/18. United Living Community was found in compliance.

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**Compliance/Noncompliance Statement**

Surveyor: 29162

A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 5/30/18 through 5/31/18. United Living Community was found in compliance.

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

Kalate C. Flight

**TITLE**

Administrator

06/22/2018

**STATE FORM**

2707F11

**RECEIVED**

JUN 25 2018

SD DOH-OLC