STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345054	A. BUILDING _____ B. WING _____	08/22/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODHAVEN NURS & ALZHEIMER'S C	1150 PINE RUN DRIVE LUMBERTON, NC 28358

(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 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview the facility failed to provide privacy while administering medications by failing to close the privacy curtain, close the window or the door for 1 of 2 residents (Resident #99)	F 164	Staff have been educated on providing full privacy while giving care. All residents have the potential to be affected by not providing privacy when giving them care because this is a dignity issue. There have been no other instances noted where privacy has not been given. The nurse in this situation was counseled by the nurse manager. This has been added to our quality assurance program to be monitored weekly times 4 weeks and if 100% compliance, then monthly. The monitoring will be done by the facilities PI/Educator nurse. Completion date for this deficiency is 9-7-12.	9-7-12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Barbara Collins RN, MSN	DON	9-6-12

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 164	Continued From page 1 observed receiving medications via a feeding tube. Findings include: Resident #99 was admitted to the facility on 4/01/11 with diagnoses of dementia, cerebrovascular accident (CVA), dysphasia, hypertension, anorexia, and severe malnutrition with a gastrostomy tube. A review of the resident's quarterly Minimum Data Set (MDS) dated 6/6/12 and annual MDS dated 3/3/12 revealed Resident #99 was severely impaired with decision making and rarely understood. The resident was totally dependant on staff for all activities of daily living and was fed by a gastrostomy tube. During an observation on 8/20/12 at 4:08 PM the medication nurse (Nurse #1) walked into the resident's room and donned gloves. Nurse #1 was observed pulling the resident ' s gown up and the resident ' s abdomen was exposed. Nurse #1 then checked for placement of the gastrostomy tube, flushed with water, administered the medications and flushed again. The door to the hall remained opened and the privacy curtain was not pulled around the resident to provide privacy. The window shade remained opened with public view to the outside. During an interview on 8/22/12 at 3:00 PM Nurse #1 stated she should have pulled the privacy curtain and closed the door to prevent unnecessary exposure of body parts while she was giving medications via the gastrostomy tube.	F 164		

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F 164	Continued From page 2 During an interview on 8/22/12 at 3:30 PM, the Director of Nursing (DON) stated her expectation was for the door to be closed, and the curtain pulled during administration of medication by tube.	F 164		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews the facility failed to provide a sanitary environment by failing to clean the tube feeding poles of feeding formula for 2 of 2 sampled residents. (Resident # 136 and Resident #63). The findings include: 1. Resident #136 was admitted to the facility on 1/9/12 with diagnoses including Dysphagia and is receiving Jevity per a gastrostomy tube. Observations were made on 8/20/12 at 4:00PM of two dried, small light brown matter on base of tube feed pole. A second observation was made on 8/21/12 at 4:00PM and the tube feeding pole was in the same condition. A third observation was made on 8/22/12 at 10:45AM and the pole was in the same condition.	F 253	All feeding pumps and poles in the facility have been cleaned. No residents were affected by this deficiency but residents that receive feedings via pump could have been affected. No dirty pumps have been identified since the survey. Staff have been educated on cleaning pumps immediately when they spill something on them. Feeding pumps will continue to be cleaned weekly as per assignment sheets. This has been added to the facilities quality assurance program to be monitored weekly times 4 weeks then monthly if 100% compliance is achieved. This monitoring will be done by our PI/Educator nurse. Completion date for this deficiency is 9-7-12.	9-7-12

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F 253	Continued From page 3 During an interview with the housekeeper on hall 1600 on 8/22/12 at 1:50PM she stated that the nursing staff is responsible for cleaning the tube feeding poles/equipment. During an interview with the charge nurse on hall 1600 on 8/22/12 at 2:00 PM she stated that the night nurses have a schedule and the tube feeder pumps and poles are to be cleaned on Tuesday nights. She stated that would have been last night and she did not know why they are not cleaned. She stated she would take care of it. Staff was observed to have cleaned the tube feed pole. Reviews of the assignment schedule posted at the nursing station showed that the tube feed poles are to be cleaned on Tuesday nights by the nursing staff. During an interview with the unit supervisor on 8/22/12 at 3:20PM she stated that it is expected that the tube feed poles be cleaned weekly on nights and there is a schedule for this. She also stated that the poles need to be checked when the nurses are doing tube feeding flushes and hanging the tube feeding to make sure the poles and floor are cleaned from to avoid roaches, ants and rats. During an interview with the Director of Nursing on 8/22/12 at 3:45PM she stated it was expected that the poles would be cleaned according to the schedule. 2. Resident #63 was admitted to the facility on 7/5/11 with diagnoses including Dysphagia and is	F 253		

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F 253	Continued From page 4 receiving Glucerna per gastrostomy tube. Observations were made on 8/20/12 at 3:10PM and the tube fed pole was observed with dried light brown matter on the base of the pole that appeared to be running down the base of the pole. A second observation was made on 8/21/12 at 4:00PM and the tube feeding pole was in the same condition. A third observation was made on 8/22/12 at 10:00AM the pole was in the same condition. During an interview with the housekeeper on hall 1600 on 8/22/12 at 1:50PM she stated that the nursing staff is responsible for cleaning the tube feeding poles/equipment. During an interview with the charge nurse on hall 1600 on 8/22/12 at 2:00 PM she stated that the night nurses have a schedule and the tube feeder pumps and poles are to be cleaned on Tuesday nights. She stated that would have been last night and she did not know why they are not cleaned. She stated she would take care of it. Staff was observed to have cleaned the tube feed pole. Reviews of the assignment schedule posted at the nursing station showed that the tube feed poles are to be cleaned on Tuesday nights by the nursing staff. During an interview with the unit supervisor on 8/22/12 at 3:20PM she stated that it is expected that the tube feed poles be cleaned weekly on nights and there is a schedule for this. She also	F 253		

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F 253	Continued From page 5 stated that the poles need to be checked when the nurses are doing tube feeding flushes and hanging the tube feeding to make sure the poles and floor are cleaned from to avoid roaches, ants and rats. During an interview with the Director of Nursing on 8/22/12 at 3:45PM she stated it was expected that the poles would be cleaned according to the schedule.	F 253		
F 371 SS=E	483.35(i) 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 observations and staff interviews the facility failed to label and date opened stock food containers, label and date refrigerated cooked foods, remove dented cans from stock shelving. Findings include: During the initial tour on 8/20/12 at 10:40 AM an observation of the reach in cooler revealed it contained the following opened containers: (1) gallon bottle of Mustard, (1) gallon bottle 1000 Island Dressing, (1) gallon bottle Ken's Sauce, (1)	F 371	All open stock food containers have been labeled with open date and "use by date". No dented cans have been identified on the shelves. Refrigerated cooked foods have been labeled and dated. No unsecured tops have been identified. Dietary staff have been educated on storing and labeling foods properly and removing dented cans from the shelves. No resident was affected by this deficiency but all residents had the potential to be affected. The DON will be conducting weekly inspections of the kitchen. This will be added to our quality assurance program to be monitored weekly times 4 weeks then monthly if 100% compliance is achieved. The monitoring will be done by our PI/Educator nurse. Completion date for the deficiency is 9-7-12.	9-7-12

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F 371	Continued From page 6	F 371		

gallon bottle of La Choy sauce, and (1) gallon Honey Mustard dressing with no date signifying when they were opened. The containers had no use by date printed on their label or container.

A tour of the reach in cooler revealed outdated food products. Products observed were: (2) 10 lab containers of salad dated to be used by 8/19/12; (1) 10 lb container of salad dated to be used by 8/13/12; (2) 10 lb containers of cabbage dated to be used by 8/07/12/ (1) 10lb container of cabbage dated to be used by 8/16/12; (1) quart bag of chopped salad vegetables with no date and one container of left over soup with no date. (2) 2 gallon containers of pickle were observed in a walk in cooler with unsecured tops and no open date.

A tour of the dry stock room revealed dented cans on storage shelving. The cans observed included: (4) 15.25 oz cans of corn; (1) 15 oz can of carrots; (1) 6 lb can of Mandarin oranges; (1) 7 lb can of strawberries; (1) 7 lb can of pork and beans; (1) 7 pound can diced tomatoes.

During an interview with the Kitchen Manager on 8/20/12 at 11:25 AM she stated the facility policy was to cover, label, and date all food products when they were opened and before they were stored in the walk in coolers. The facility policy was to discard all cooked food after 3 days. She revealed staff had no way of knowing when food was opened or when it needed to be discarded if there was no date. She reported the policy stated all dented cans were to be put in a separate area when the shelves were stocked She indicated staff had all been trained and were aware food was to be dated and dented cans were to be

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F 371	Continued From page 7 separated and returned to US Foods for a credit. An interview was conducted with the Director of the facility on 8/23212 at 3:30 PM. She stated staff had been trained and knew how to store items properly. She revealed it was her expectation dietary staff would follow facility policy.	F 371		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to	F 431	The refrigerator temperature was corrected immediately when it was found. the maintenance man adjusted the temperature control which had been set too high. There was not anything found to be malfunctioning with the refrigerator. All refrigerators have been defrosted. No residents were affected by the deficiency but residents receiving medications from the refrigerator that had the wrong temperature could have been affected. The Staff have been educated on ensuring the refrigerators are registering the correct temperature and are being defrosted weekly as assigned. No other deficient practice with the refrigerators have been noticed. The staff will continue to monitor the medication refrigerators twice a day. This will be added to our quality assurance program to be monitored weekly times	

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F 431	Continued From page 8 abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, facility record review and staff interviews the facility failed to maintain a refrigerator temperature between 36 - 46 degrees for 1 of 4 medication refrigerators and failed to defrost 4 of 4 medication refrigerator freezers observed. The findings include: During an observation of the refrigerator on hall 1200 on 8/22/12 at 2:00PM the temperature read 26 degrees Fahrenheit. The refrigerator was noted to have one vial of Pro-Crit used to treat Anemia, one vial of Tuberculin Purified Protein Derivative used for tuberculin testing and one vial of insulin in the refrigerator. These medications, per manufacturer recommendations, are to be stored between 36-46 degrees Fahrenheit. The freezer was noted to have approximately one inch of ice on all sides. During a second observation of the refrigerator on hall 1200 on 8/22/12 at 2:45PM the temperature read 30 degrees Fahrenheit. During an observation of the refrigerator on hall 1100 on 8/22/12 at 2:15PM the freezer was observed to have approximately one inch of ice on all sides.	F 431	4 weeks then monthly if 100% compliance is achieved. The monitoring will be done by our PI/Educator nurse. Completion date for this deficiency is 9-7-12.	9-7-12

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F 431	Continued From page 9 During an observation of the two refrigerators on hall 1600 on 8/22/12 at 2:30PM the freezers were observed to have approximately two inches of ice surrounding all sides of the freezer. Review of the 24-hour assignment sheet read at the bottom, in part, " Sunday: Defrost all refrigerators. " During an interview with the nurse on hall 1600 on 8/22/12 at 2:30PM she stated that the night shift is supposed to be defrosting the freezers but it did not look like it had been done. During an interview with the charge nurse on hall 1200 on 8/22/12 at 2:45PM she stated the low temperatures may be because of all of the ice in the freezer but she would have maintenance check it. During an interview on 8/22/12 at 3:00PM with the Unit Supervisor for hall 1600 she stated that it is expected that the freezers be defrosted weekly. She also stated that the maintenance department had checked the refrigerator temperature and noted that the control in the refrigerator had been turned to the coldest setting and this was why the refrigerator temperature was so low. The gauge had been turned up to a higher setting. During an interview with the Director of Nursing on 8/22/12 at 3:45PM she stated that it was expected that the freezers be defrosted according to the weekly schedule and the temperatures maintained between 36-46 degrees Fahrenheit.	F 431		
F 456 SS=E	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION	F 456	All deficient areas were corrected during the survey immediately. No other deficiant	

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F 456	Continued From page 10 The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain kitchen equipment in a sanitary condition for 1 of 1 freezers, 1 of 1 sanitizing sinks, 2 of 2 ventilation fans, 1 tray transportation cart, and 2 shelving units. Findings include: During the initial tour of the kitchen on 8/20/12 at 10:40 AM the walk in freezer was observed to have a thick buildup of ice located under the fans in the back of the unit. Ice several inches thick and extending down approximately 6 inches from the fans was noted. Water was observed dripping from the ice into the freezer interior. The floor of the freezer had a large serving tray size area of ice on the floor at the entrance door. Food products, the wall sides, and the plastic hanging flaps at the door were all cover with a ¼ inch buildup of ice crystals. The pot sanitizing sink was observed during a hand wash cycle for pots and pans. The water temperature in the sink was 160 degrees. Sanitation guidelines require submersion in water greater than 171 degrees for 15 seconds for items to be safely sanitized. Two electric fans were used for ventilation in the kitchen. Each of the fan guards had a film of	F 456	areas have been identified in the kitchen. No resident was affected by this deficiency but all residents had the potential to be affected. The dietary staff have been educated on the survey findings and overall cleanliness of the kitchen. They have also been educated on the correct temperatures of the sanitation sink and the importance of making sure the freezer is free of ice build-up. They have also been educated on keeping all carts, racks, and shelving units clean and free of dust, food, or grease. The DON has started a weekly walk through of the kitchen. This will be added to our quality assurance program to be monitored weekly times 4 weeks then monthly if 100% compliance is achieved. The monitoring will be done by our PI/Educator nurse. Completion date for this deficiency is 9-7-12.	9-7-12

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F 456	Continued From page 11	F 456		

grease buildup with dust embedded. One of the fans was positioned directly above the kitchen standing mixer.

A cart used to transport trays to the Hospice center was noted have grease build up with food particles on the cart.

A 4 rack shelving unit was observed to be in use for air drying dishes in the kitchen. Lean cups and bowls were inverted on trays placed on the shelving unit. The unit was noted to have heavy dust and grease buildup.

A green 5 rack shelving unit was noted directly across from the dishwasher. The shelves contained (10) 28 oz resident ice cups with tops and straws inverted to air dry with direct contact to the unit. The selves were observed to have a heavy grease build up, dust, and a thick sticky yellow substance on the shelves.

During an intervention with the Kitchen Manager on 8/20/12 at 11:35 AM she stated the kitchen had a cleaning schedule staff were expected to follow. She indicated Maintenance was responsible for fixing the freezer and they had been contacted twice to correct the ice build up problem. The Manager revealed Maintenance was responsible for cleaning the fans once a month. She indicated food carts are to be cleaned 4 times a week and sanitized three times a week. The Manager stated she was not aware the assigned cleaning had not been done. A review of the cleaning schedule did not reveal any assigned cleaning of shelving storage units.

An interview was conducted with the Director of

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F 456	Continued From page 12 the facility on 8/23/12 at 3:30 PM. She stated she was very disappointed with the findings in the kitchen. She indicated staff had been trained and given a cleaning schedule. She revealed it was her expectation staff would adhere to the cleaning schedule and maintain a clean and safe kitchen.	F 456		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345054	A. BUILDING 01 - MAIN BUILDING 01 B. WING	09/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODHAVEN NURS & ALZHEIMER'S C	1150 PINE RUN DRIVE LUMBERTON, NC 28358

(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 Surveyor: 27871 This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the Existing Health Care section of the LSC and its referenced publications. This building is Type III(211) construction, one story, with a complete automatic sprinkler system. Facility is using NCSBC special locking. The deficiencies determined during the survey are as follows:	K 000		
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 10:30 am onward, the following items were noncompliant, specific findings include: staff did not know where emergency release switch was located at nurse station to release locking system for mag locks(1200) wing. 42 CFR 483.70(a)	K 038	We are in the process of educating every staff member on the over-ride switch that is located inside each door key pad. No resident was affected by this deficiency but all residents had the potential to be affected. This will be added to our quality assurance program so staff will be drilled weekly times 4 weeks then monthly on the use of the over-ride switches.	9-28-12
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to	K 056	The chime strobe device was replaced the day of the survey No other deficient chimes were identified. No resident was affected by this deficiency	

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

Barbara Collins RN, MSN — DON — 9-27-12

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.

GW

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OMB NO. 0938-0391

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K 056	Continued From page 1 provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 10:30 am onward, the following items were noncompliant, specific findings include: chime was not working on 1100 hall by room 1106 and 1108 when fire alarm was on test.	K 056	but all residents could have been. It is not necessary to add this to our quality assurance program. The maintenance department and Simplex will monitor this once a quarter with the sprinkler checks.	9-13-12
K 062 SS=E	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 10:30 am onward, the following items were noncompliant, specific findings	K 062	The tamper switch has been ordered. Simplex is being lined up to do the work. No other deficient areas were identified. It is not necessary to add this to our quality assurance program. The maintenance department and Simplex will monitor the tamper switch quarterly.	10-27-12

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K 062	Continued From page 2 Include: valve connected to accelerator was not electrical supervised to send signal to fire alarm control panel(riser room). 42 CFR 483.70(a)	K 062		
K 067 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 10:30 am onward, the following items were noncompliant, specific findings include: damper located on 1200 in attic near room 1202 did not close on fire alarm test. 42 CFR 483.70(a)	K 067	This was corrected the day of the survey. No other deficient dampers have been identified. No residents were affected by this deficiency but all residents could have been. It is not necessary to add this to our quality assurance program. This will be checked annually by our maintenance department and Simplex.	9-13-12

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	345054	A. BUILDING 02 - BUILDING 2 B. WING _____	09/12/2012

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K 000	INITIAL COMMENTS Surveyor: 27871 No LSC deficiencies noted at time of survey. 42 CFR 483.70(a0	K 000		

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

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