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
	345167	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YADKIN NURSING CARE CENTER	**903 W MAIN STREET** **YADKINVILLE, NC 27055**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation survey completed 12/3/18-12/6/18. Event ID# LAX311.	F 000		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;	F 623		1/3/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 12/29/2018

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 623	Continued From page 1 (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the	F 623		

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F 623 Continued From page 2
agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on record review, staff interviews and interview with the Ombudsman, the facility failed to notify or provide a copy of the transfer/discharge notice to the Ombudsman for 2 of 2 residents (Residents #101 and 66) reviewed for hospitalization.

Findings included:

1. Resident #101 was admitted to the facility on 10/26/17 with diagnoses that included, in part, anemia and non-Alzheimer's dementia.

A review of the most recent comprehensive minimum data set (MDS) assessment dated

F 623

F623
STANDARD DISCLAIMER:
This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid programs and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s).

This requirement was not met as evidenced by:

Based on record review, staff interviews and interview with the Ombudsman, the facility failed to notify or provide a copy of

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F 623	Continued From page 3 10/26/18 revealed Resident #101 had moderately impaired cognition. A review of the medical record revealed Resident #101 was transferred to the hospital on 11/15/18 due to decreased level of consciousness and respiratory distress. The resident expired at the hospital. A written notice of transfer was sent to Resident #101's representative but no written notice of transfer was documented to have been provided to the Ombudsman. On 12/6/18 at 12:25 PM an interview was completed with the Business Office Manager. She stated the facility was unaware of the requirement to send a copy of the transfer/discharge notice to the Ombudsman when a resident was sent to the hospital and therefore, had not sent a copy of the notice nor notified the Ombudsman when Resident #101 transferred to the hospital. On 12/6/18 at 12:32 PM an interview was completed with the facility Social Worker. She reported she was unaware of the requirement to send a copy of the transfer/discharge notice to the Ombudsman when a resident was sent to the hospital and had not notified the Ombudsman of Resident #101's transfer to the hospital. On 12/6/18 at 12:48 PM an interview was completed with the Director of Nursing (DON). She said she was unaware of the regulation that the Ombudsman be notified when a resident transferred to the hospital and said she expected that going forward a copy of the transfer/discharge notice be sent to the	F 623	the transfer/discharge notice to the Ombudsman for 2 of 2 residents (Residents #101 and 66)reviewed for hospitalization. The Ombudsman has been notified for the transfers of Resident #□s 101 and 66. For all other residents having the potential to be affected by this alleged deficient practice, the facility Business Office shall make notification to the Ombudsman□s Office as soon as is reasonably practicable following a resident□s transfer and/or discharge from the facility. To ensure compliance the Business Office Manager shall prepare a once per week reconciliation of residents who are transferred/discharged from the facility within the previous seven days and ensure the Ombudsman has been notified. Any transfer/discharge identified as not having been transmitted to the Ombudsman shall be transmitted by either secure email, fax or other secure means of notification. Weekly reconciliations shall occur weekly for 4 weeks and shall occur monthly thereafter. The weekly transfer/discharge reconciliations shall be reviewed by the Quality Assurance Committee weekly for 4 weeks and monthly for three months to ensure compliance with the systematic notification requirements to the Ombudsman□s Office.	

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Ombudsman when a resident transferred to the hospital.

On 12/6/18 at 1:07 PM an interview was completed with the Ombudsman. She said the facility had not sent her any notices of residents who transferred to the hospital.

2. Resident #66 was admitted to the facility on 7/2/18 with diagnoses that included, in part, coronary artery disease, congestive heart failure and dementia.

A review of the most recent comprehensive minimum data set (MDS) assessment dated 11/23/18 revealed Resident #66 had moderately impaired cognition.

A review of the medical record revealed Resident #66 was transferred to the hospital on 11/4/18 after he sustained a fall. Resident #66 was re-admitted to the facility on 11/9/18. A written notice of transfer was sent to Resident #66's representative but no written notice of transfer was documented to have been provided to the Ombudsman.

On 12/6/18 at 12:25 PM an interview was completed with the Business Office Manager. She stated the facility was unaware of the requirement to send a copy of the transfer/discharge notice to the Ombudsman when a resident was sent to the hospital and therefore, had not sent a copy of the notice nor notified the Ombudsman when Resident #66 transferred to the hospital.

On 12/6/18 at 12:32 PM an interview was completed with the facility Social Worker. She

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F 623	Continued From page 5 reported she was unaware of the requirement to send a copy of the transfer/discharge notice to the Ombudsman when a resident was sent to the hospital and had not notified the Ombudsman of Resident #66's transfer to the hospital. On 12/6/18 at 12:48 PM an interview was completed with the Director of Nursing (DON). She said she was unaware of the regulation that the Ombudsman be notified when a resident transferred to the hospital and said she expected that going forward a copy of the transfer/discharge notice be sent to the Ombudsman when a resident transferred to the hospital. On 12/6/18 at 1:07 PM an interview was completed with the Ombudsman. She said the facility had not sent her any notices of residents who transferred to the hospital.	F 623		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information	F 636		1/3/19

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F 636	Continued From page 6 (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section,	F 636		

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F 636	Continued From page 7 "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on staff interviews and medical record review, the facility failed to complete an annual comprehensive assessment within 366 days for 1 of 28 residents (Resident # 9) reviewed for comprehensive assessments. The findings included: Resident #9 was admitted to the facility on 11/18/14 with diagnoses that included, in part, anemia, hyperlipidemia and dementia. A review of the quarterly Minimum Data Set (MDS) Assessment dated 7/27/18 revealed Resident #9 had severely impaired cognition. A review of the annual MDS assessment dated 10/26/18 revealed the assessment was in progress and had not been completed. Further review of assessments revealed the previous annual MDS assessment was completed 10/27/17. An interview was completed with the MDS Coordinator on 12/5/18 at 10:53 AM. She said the annual MDS assessment for Resident #9 should have been completed by 11/9/18. She stated she had all the data for the assessment but had not entered it in the computer. She further stated the facility typically had two MDS nurses but one was out on leave. An interview was completed with the Director of	F 636	F636 STANDARD DISCLAIMER: This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid programs and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s). This requirement was not met as evidenced by: Based on staff interviews and medical record review, the facility failed to complete an annual comprehensive assessment within 366 days for 1 of 28 residents (Resident #9) reviewed for comprehensive assessments. The comprehensive annual assessment for Resident #9 has been completed. The root cause of the oversight was human-related. For those residents with the potential to be affected by the same alleged deficient practice, the MDS Coordinator has completed a 100% audit of all Annual Comprehensive Assessments due since November 1, 2018 to ensure the assessments have been completed as prescribed. To ensure compliance on an ongoing basis, the MDS Coordinator shall	

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F 636	Continued From page 8 Nursing (DON) on 12/5/18 at 3:50 PM. During the interview a concern regarding residents' assessments not being completed timely was discussed. When asked, the DON stated she expected the MDS assessments be completed within the required time frame.	F 636	provide to the Business Office Manager or other administrative designee the list of annual comprehensive assessments to be completed within the next 30 days. At the end of the prescribed 30 days, the Business Office Manager or designee shall reconcile the listing of the comprehensive annual assessments that have been completed against the list of those that are due. Similarly, the reconciliation shall include the date upon which the annual comprehensive assessment was to be completed and the actual date the assessment was completed to ensure the assessment(s) are completed within period of time defined by the RAI Manual. The Business Office Manager shall present the reconciliation of the Comprehensive Annual Assessment reconciliation(s) to the Quality Assurance Committee monthly for three months and quarterly thereafter.	
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to conduct quarterly Minimum Data Set (MDS) assessments for 4 of 28 residents reviewed for Resident Assessments. (Resident #	F 638	F638 STANDARD DISCLAIMER: This Plan of Correction is prepared as a	1/3/19

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5, 3, 24, and 19)

Findings:

1. Resident # 5 was admitted to the facility on 4/17/17 with diagnoses of: heart failure, unspecified dementia without behavioral disturbance, major depressive disorder, cardiac arrhythmia, edema, chronic ischemic heart disease, and unspecified retinal vascular occlusion.

A review of Resident # 5's MDS assessments revealed resident's last completed assessment was a quarterly assessment dated 7/20/18. Further review of Resident # 5's assessments revealed a quarterly assessment dated for 10/19/18 that was "in progress" and had not been completed.

An interview was conducted on 12/05/18 at 01:47 PM with the MDS coordinator who acknowledged that Resident # 5's MDS quarterly assessment dated 10/19/18 and an Assessment Reference Date (ARD) date of 11/2/18 should have been completed.

During an interview with the Director of Nursing (DON) on 12/06/18 at 09:35 AM, she stated that it was her expectation that quarterly MDS assessments would be completed as required.

2) Resident #3 was admitted to the facility on 7/18/16 with a cumulative diagnoses which included rheumatoid arthritis and osteoarthritis.

A review of Resident #3 ' s Minimum Data Set (MDS) assessments was conducted on 12/3/18 at 12:41 PM. This review revealed an annual

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necessary requirement for continued participation in the Medicare and Medicaid programs and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s).

This requirement was not met as evidenced by:

Based on record reviews and staff interviews, the facility failed to conduct quarterly Minimum Data Set (MDS) assessments for 4 of 28 residents reviewed for Resident Assessments. (Resident #5, 3, 24, and 19)

The Quarterly MDS Assessments for Resident #□s 5, 3, 24 and 19 have been completed.

For those residents with the potential to be affected by the same alleged deficient practice, a retrospective audit of quarterly MDS assessments beginning on 10/01/2018 has been completed in order to identify if there were other Quarterly MDS Assessments which had not been completed pursuant to the prescribed timeframe. Any Quarterly MDS Assessments identified as not having been completed have been completed. In addition to those identified herein, there were 31 of Quarterly MDS Assessments identified as not having been completed timely.

To ensure compliance, the Business Office Manager or other administrative designee who has been trained to

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MDS assessment with an Assessment Reference Date (ARD) of 7/20/18 had been completed for Resident #3. However, a review of the resident ' s most recent quarterly MDS (with an ARD of 10/19/18) revealed the quarterly assessment remained "Open" and was not completed. Further review of the 10/19/18 MDS assessment included Section Z. Section Z (Z0500) of the MDS was not signed or dated by a nurse to indicate the assessment had been completed.

An interview was conducted on 12/5/18 at 8:55 AM with the facility ' s MDS Coordinator. Upon request, the MDS Coordinator reviewed Resident #3 ' s quarterly MDS dated 10/19/18 and confirmed this assessment had not yet been completed. When asked, the MDS Coordinator stated the MDS assessment should have been completed and signed by 11/2/18. The MDS Coordinator reported the facility typically had two MDS nurses, but was currently, "short one MDS person."

An interview was conducted on 12/5/18 at 3:50 PM with the facility's Director of Nursing (DON). During the interview, a concern regarding residents' MDS assessments not being completed within 14 days after the ARD date was discussed. When asked, the DON stated she would expect the MDS assessments to be completed within the required time frame.

3) Resident #24 was admitted to the facility on 3/6/15 with a cumulative diagnoses which included dementia and hemiplegia (a form of paralysis that affects one side of the body).

A review of Resident #24 ' s Minimum Data Set (MDS) assessments was conducted on 12/3/18

F 638

examine the due and completion dates of the Quarterly MDS Assessments shall audit the due dates and subsequent completion dates of all Quarterly MDS Assessments weekly for 4 weeks and monthly thereafter using the Quarterly MDS Assessment Due/Completion Audit Tool. Subsequent to 4 weeks of weekly review, such audits shall be completed monthly for 3 months and quarterly thereafter.

The Business Office Manager or other administrative designee shall present the findings of the audits to the facility's Quality Assurance Committee weekly for 4 weeks, monthly for three months and quarterly thereafter.

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F 638	Continued From page 11	F 638		

at 2:36 PM. This review revealed a quarterly MDS assessment with an Assessment Reference Date (ARD) of 8/24/18 had been completed for Resident #24. However, a review of the resident ' s most recent quarterly MDS (with an ARD of 11/16/18) revealed this quarterly assessment remained "Open" and was not completed. Further review of the 11/16/18 MDS assessment included Section Z. Section Z (Z0500) of the MDS was not signed or dated by a nurse to indicate the assessment had been completed.

An interview was conducted on 12/5/18 at 8:55 AM with the facility ' s MDS Coordinator. Upon request, the MDS Coordinator reviewed Resident #24 ' s quarterly MDS dated 11/16/18 and confirmed this assessment had not yet been completed. When asked, the MDS Coordinator stated the MDS assessment should have been completed and signed by 11/30/18. The MDS Coordinator reported this assessment was on her list and that she was currently working on it. "It will be completed very soon." The MDS Coordinator reported the facility typically had two MDS nurses, but was currently, "short one MDS person."

An interview was conducted on 12/5/18 at 3:50 PM with the facility's Director of Nursing (DON). During the interview, a concern regarding residents' MDS assessments not being completed within 14 days after the ARD date was discussed. When asked, the DON stated she would expect the MDS assessments to be completed within the required time frame.

4. Resident #19 was admitted to the facility on 8/4/17 with diagnoses that included, in part, cerebrovascular accident and non-Alzheimer's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345167	A. BUILDING ______ B. WING ______	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YADKIN NURSING CARE CENTER	903 W MAIN STREET YADKINVILLE, NC 27055

(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 638	Continued From page 12 dementia. A review of the comprehensive Minimum Data Set (MDS) Assessment dated 5/23/18 revealed Resident #19 had impaired short term and long term memory and severely impaired decision making skills. A review of the quarterly MDS assessment dated 11/2/18 revealed the assessment was in progress and had not been completed. Further review of assessments revealed the previous quarterly MDS assessment was completed 8/17/18. An interview was completed with the MDS Coordinator on 12/5/18 at 10:53 AM. She said the quarterly MDS assessment for Resident #19 should have been completed by 11/16/18. She stated she had all the data for the assessment but had not entered it in the computer. She further stated the facility typically had two MDS nurses but one was out on leave. An interview was completed with the Director of Nursing (DON) on 12/5/18 at 3:50 PM. During the interview a concern regarding residents' assessments not being completed timely was discussed. When asked, the DON stated she expected the MDS assessments be completed within the required time frame.	F 638		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:	F 641		1/3/19

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F 641	Continued From page 13 Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment for a resident receiving an opiod for 1 of 1 (Resident #18) residents reviewed for Unnecessary Medications. Findings included: Resident #18 was admitted to the facility on 11/18/16 with multiple medical diagnoses including chronic pain. A review of the quarterly MDS assessment dated 8/17/18 revealed the resident did not receive an opiod during the 7 days of the look back period. A review of the physician orders dated August 2018 revealed an order for Ultram 50 milligrams by mouth three times a day for pain. A review of the Medication Administration Record for August 2018 revealed Ultram 50 milligrams by mouth three times a day was documented as given for 7 out of 7 days during the look back period. An interview on 12/6/18 at 9:14 AM with the MDS nurse revealed Resident #18 did receive an opiod 7 out of 7 days of the look back period and it should have been coded on the MDS, but she must have forgotten to enter it. An interview on 12/6/18 at 1:38 PM with the Director of Nursing revealed she expected the MDS assessment to be coded accurately.	F 641	F641 STANDARD DISCLAIMER: This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid programs and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s). This requirement was not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment for a resident receiving an opioid for 1 of 1 (Resident #18) residents reviewed for Unnecessary Medications. The MDS assessment for Resident #18 has been corrected to reflect the usage of an opioid. The omission was due to an oversight in the completion of the initial MDS. For those residents having the potential to be affected by the same alleged deficient practice, all resident MDS□s completed since December 6, 2018 to ensure the MDS□s are coded to reflect the residents□ medication utilization during the lookback period. To ensure compliance, the MDS Coordinator or authorized designee, shall audit 100% of all MDS□s completed within a 7-day period for four weeks to ensure medication utilization is properly	

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F 641	Continued From page 14	F 641	coded. Subsequently, the MDS Coordinator or authorized designee shall audit 50% of all MDS□s completed within the previous 30-days for one month to ensure medication utilization is properly coded. Monthly audits shall be completed for 3 months. The MDS Coordinator shall present the results of each series of audits to the Quality Assurance Committee in order for the Committee to evaluate the systematic approaches to ensure compliance. Weekly audits shall be reviewed weekly by the Quality Assurance Committee for 4 weeks and monthly audits shall be reviewed on a monthly basis for 3 months. Subsequent audits shall be reported and reviewed quarterly by the Committee.	