STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345523	A. BUILDING _____ B. WING _____ OCT 05 2012	08/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/RAMSEUR	7166 JORDON ROAD RAMSEUR, NC 27316

(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 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, medical record reviews and staff interviews the facility failed to provide restorative nursing according to the plan of care for 1 of 29 residents Resident #52 The findings were: Resident #52 was admitted to the facility on 4/18/12 with diagnoses including history of stroke, Atrial Fibrillation, Congestive Heart Failure, and Depression. Review of the Minimum Data Set dated 6/15/12 revealed Resident #52 required extensive assistance by one staff member for bathing, hygiene, dressing and transfers. Review of the care plan dated 7/13/12 revealed a problem in the area of " Self care deficit r/t (related to) deconditioning w (with)/multiple chronic health problems, requires staff assistance for ADLs (Activities of Daily Living) ". The goal for Resident #52 was for him to be able to participate in part of ADLs daily, put his arms through the sleeves with limited assistance by staff. Review of the approaches for this problem/need were for staff to provide care for	F 282	**Submission of this response to the statement of deficiencies does not constitute an admission that the deficiencies exist and/or were correctly cited or required correction.** **.F 282** Resident # 52 had been on this restorative plan for four days at the time of the observation. Resident #52 participated in over 50% of the activities involved, washing, shaving, and putting his arms through a shirt that was held by the CNA and putting his leg into his pants held by the CNA. He was partially meeting his goal on his fifth day on the program. Documentation on the RNS flow sheet stated that resident did not want to fully participate. A refusal was not documented because Resident #52 participated in the program.	8-30-12

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

Christine Peer Lawrence Administrator 10-1-12

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 282	Continued From page 1 him to be dressed, groomed and bathed. Other approaches were for Resident #52 to receive oral, perineal and personal hygiene every day and as needed. The staff were to give Resident #52 verbal cues to help prompt as indicated, encourage and allow him to do as much as possible for himself, then provide needed care to complete tasks. Review of the careplan revealed these services were to be provided by the aides on the floor and restorative nursing assistants. Review of a therapy note signed by the physical therapist on 7/5/12 revealed their services were extended to cover Resident #52 from 7/6/12 to 8/16/12. Review of the therapy plan of care revealed the goal for Resident #52 was to be discharged to home. Further review revealed Resident #52 would need to have modified assistance with all mobility. Resident #52 was discharged from physical therapy on 7/26/12. Therapy referred the resident to restorative for bed mobility and walking training. Occupational therapy discharged Resident #52 to restorative services on 6/29/12. Review of the Restorative careplan that was initiated by staff on 7/28/12 for Dressing/Grooming revealed the goals set for Resident #52 were to bathe and dress his upper body with supervision, bathe and dress his lower body with supervision to minimal assist, and don & doff(put on and take off) his shoes with modified independence. Staff were to practice above dressing and grooming with each encounter. Notify the nurse of any change in his ability to participate. Interview on 8/1/12 at 8:53 AM with restorative	F 282	**F 282** **1. The following was accomplished for Resident #52 who was affected by the practice:** Resident #52 was visited and encouraged by the DON on 8-3-12 to participate as much as possible in the restorative program by doing for himself. Resident stated "Sometimes I just don't feel like doing it and I told her (Aide#3) that". CNA#3 was in serviced on the need to offer cues and encouragement to the resident to perform all parts of the restorative program. **2. The following was accomplished for residents having the potential to be affected by the practice:** All CNAs qualified to perform restorative services were in serviced on the need to offer cues and encouragement to the	8-30-12

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F 282	Continued From page 2 aide # 1 revealed she had started today with restorative for Resident #52. During this interview, it was revealed she would work with him 2 times a week (minimum), in the areas of ambulation, transfer to and from the bathroom, to and from the wheelchair, bed mobility, sit to stand, and dressing and grooming. Further interview revealed the aides on the floor would do restorative, when the Restorative Nursing Assistants did not get to him. It was explained the aides on the floor had been providing restorative care from 7/28/12 to present. (8/1/12) Observations on 8/1/12 at 10:06 AM, aide # 3 revealed Resident #52 was assisted to transfer from bed to chair, and then transfer from chair to toilet. Aide # 3 gave the washcloth to the resident and asked him to wash his face. Resident #52 proceeded to wash his face without refusing. Aide # 3 proceeded to wash his trunk, arms, upper thighs and toes. Aide # 3 then had Resident #52 stand and his buttocks were washed. After rinsing and drying the resident ' s skin, a disposable brief and clothing were applied by aide # 3. Lastly, aide #3 put both shoes on Resident #52. During these observations aide #3 did not ask, or encourage Resident #52 to provide the care for himself, or request him to assist in providing the care. The two tasks performed by the resident were washing his face and using an electric razor for shaving. An interview was conducted with aide #3 on 8/1/12 at 10:30 AM. During this interview, it was revealed she was trained in the restorative needs for Resident #52. Continued interview revealed she was able to recite the restorative care plan for the areas the resident should perform and the	F 282	**F 282** residents to perform all parts of their restorative program. The DON reviewed all restorative plans with the Lead Restorative Aide on 8-3-12 to ensure that the plans were being followed and the plans were effective. No other issues with refusals were noted. **3. The following measures/systems were put in place to ensure that the deficient practice does not occur:** The Lead restorative Aide will review all RNS programs weekly to determine if a resident has refused the program more that 2x that week, other than for illness or other unavoidable circumstances. The Lead Restorative Aide will review the refusals with the DON weekly and the plans/goals will be revised as needed. The Lead Restorative Aide will maintain a log of residents with consistent refusals and the date of the restorative plan revisions.	8-30-12

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F 282	Continued From page 3 care she was to provide. An interview with aide # 3 on 8/1/12 at 3:06 PM revealed Resident #52 usually refused to do more for himself during restorative. Continued interview revealed the aide knew Resident #52 was supposed to do as much as possible. The interview concluded with the explanation as to why she performed the tasks for him was due to Resident #52 would say " that was why he was here, for staff to do for him. " An interview was conducted on 8/1/12 at 3:11 PM with the RNA # 1. During this interview, this staff member had no reports by the aides on the floor regarding refusals to participate in restorative by Resident #52. Further interview revealed, any problems the aides on floor would encounter while providing restorative would be reported to Nursing Administrative staff member #1. An interview was conducted on 8/1/2 at 3:14 PM with the Nursing Administrative staff member #1 who was supervising the restorative care. During this interview it was revealed the aides on floor were the main staff that provided restorative services. The Restorative aide was over them (aides on the floor). During this interview, the question was asked as to how the administrative nursing staff supervised the aides to ensure restorative services were provided. This Nursing Administrative staff member #1 replied, by reviewing the signed flowbooks and making rounds. The nursing management team did random rounds, monitored different things, and restorative was a part of it. The next question asked during this interview was about documentation on the restorative flowsheets.	F 282	**F 282** **4. The following monitoring initiative was put in place to ensure that the corrective action is achieved and maintained:** The DON and/or ADON will review all RNS programs weekly for one month and observe the provision of the restorative service to ensure that the plan is followed, encouragement provided and refusals/progress is documented appropriately. An audit sheet will be maintained and findings brought to the QA committee for review and revisions of the corrective action as needed. will be audited weekly by the DON or designee to ensure that the update and documentation is in place. Results of these audits will be integrated in to the QA process and reported to the QA committee. Corrective action will be revised as needed and the audit will continue as determined by the committee.	8-30-12

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F 282	Continued From page 4 The Nursing Administrative staff member #1 was asked how the aides documented any refusals or lack of participation in restorative. The response was provided as: If a resident does not participate, and the area was refused, the aides would notify her or the RNA in writing. If for 3 days restorative is refused by a resident, she would pick up on it. Either the RNA or she would check on it. Continued interview revealed she had not received any communication that Resident #52 was refusing restorative. The interview concluded with the review of the documentation on the restorative flowsheets. According to what was documented for the past five days, she confirmed Resident #52 had received restorative services according to the care plan. This was evidenced by the initials by the aides for each part of the restorative services. She confirmed there were no refusals documented for the past five days.	F 282	**F371** **1. The following was accomplished for the practice:** The Dietary Manager cleaned the pencil point spots on the gasket and upper area of storage bin immediately. There were no spots in the area where ice is stored. **2. The following was accomplished for other areas having the potential to be affected by the practice.** Other ice machines were checked to ensure that there were no dark spots inside the ice machines. All other ice machines were free of dark spots. An in-service was held on 8-23-12 with all Dietary Staff on the proper methods of cleaning and sanitizing the ice machine. **3. The following measures or systemic changes were put in place to ensure that the practice does not occur:**	8-30-12
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 kitchen observation and staff interview the facility failed to clean and maintain one of one	F 371		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 371	Continued From page 5 ice machines. The findings include: An initial tour of the Kitchen was conducted on 7/30/12 at 9:30 AM with the Dietary Manager. The facility ice machine was observed at 9:50 AM. The ice machine shield located above the ice inside the bin was observed to have scattered clusters of dark green / black spots approximately 0.5 millimeters in size. Multiple clusters of the dark green/black spots were observed on the inside, top, and right side of the storage bin. The Dietary Manager stated the spots were permanent stains on the plastic. The Manager used a clean wet paper towel and wiped off the shield, top, and sides of the ice bin. The dark spots wiped off. The Manager stated the spots were mold. An interview was conducted with the Dietary Manager after the kitchen tour. The Dietary Manager reported the ice machine was scheduled to be cleaned weekly by kitchen staff. She revealed she had been on vacation the week before and suspected her staff had not cleaned the ice bin. The Dietary Manager indicated the ice machine would be thoroughly cleaned and maintained on a weekly basis from now on. During an interview with the facility Administrator on 7/31/12 at 3:10PM she stated it was her expectation the ice machine would be clean and mold free.	F 371	The Dietary Stock person is assigned to clean the ice machine weekly according to specifications. The Dietary Manager or designeewill check the cleanliness of the machine 5 out of 7 days to ensure that the cleaning has been accomplished and the cleaning schedule is appropriate. Both the Stock person and the Dietary Manager will sign-off on the check sheet that their tasks have been completed. **4. The following monitoring initiative will be put in place to ensure that the correct action is sustained and achieved:** The ice machine cleanliness audits and findings will be presented to the QAA committee and the plan will be integrated into the QA program. The QAA committee will review the results of the audits and make changes to the plan or audit as deemed necessary. The audit will continue as determined by the QAA committee.	8-30-12
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an	F 441		

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F 441	Continued From page 6 Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by:	F 441	**F 441** CNA's #4 and #1 caused cross-contamination potential during the observation. Both said that nervousness was the factor and recited the correct procedures for the surveyor. The CNA's were aware of their mistake as soon as it occurred. **1. The following was accomplished for Resident #104 and Resident #17 who were affected by the practice:** Resident #104: Pericare per policy was performed by the assigned CNA #4. The Resident was assessed by the DON and has had no symptoms of UTI, infections or negative outcomes related to cross contamination as of 8-27-12. The Hoyer pad was laundered immediately per facility policy and the Hoyer lift was sanitized with a 10% bleach solution. CNA#4 was in serviced and observed by the DON performing pericare per policy with no cross contamination on 8-2-12.	8-30-12

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F 441	Continued From page 7 Based on observations and staff interviews the facility failed to prevent cross contamination during incontinence care for two of three residents that received incontinence care. Resident # 104 and Resident # 17 The findings were: 1. Observations on 7/30/12 at 3:55 PM revealed incontinence care was provided by aide # 4. Aide #4 cleaned stool from the buttocks using incontinence wipes from a package. Aide # 4 was observed keeping the same gloves on, and getting a different wipe out of the package several times during the observations. The gloved hand used to clean the stool was used to obtain the wipes for each use. After the stool was cleaned, incontinence care was provided to the front perineum while keeping the same gloves on to provide the care. After the incontinence care was provided, aide #4 kept the dirty gloves on both hands, a lift pad was obtained and placed under Resident #104. The lift pad was observed to be attached to the total lift onto the hooks. Aide #4 then proceeded to use the control device and maneuver the lift with the dirty gloves still on both hands. Continued observations revealed aide #4 took the lift out of the room and placed it in a storage area. Aide # 4 washed his hands and proceeded down the hall. The lift was not observed to be cleaned before being stored. Interview with aide #4 on 7/30/12 at 4:12 PM revealed after the stool had been cleaned from Resident #104 ' s skin, the dirty gloves should have been removed. He then would have washed his hands, and put on a clean pair of gloves to complete the care and use the lift.	F 441	Resident #17: Pericare per policy was performed by CNA #1. Resident # 17 was assessed by the DON and had shown no signs and symptoms of UTI, infections or negative outcomes related to cross contamination as of August 27, 2012. CNA #1 was in serviced and observed performing pericare per policy with no cross contamination on 8-2-12 by the ADON. **2. The following was accomplished for those residents having the potential to be affected by the practice:** All CNAs were in serviced by the DON and ADON on 8-3-12 on providing pericare per policy to prevent cross contamination. **3. The following measures or systemic changes were put in place to ensure that the deficient practice will not occur:** Pericare to prevent cross contamination in-servicing will be provided to each CNA every two months. Pericare to prevent cross contamination will also be included on the yearly CNA Skills Checklist.	8-30-12

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F 441	Continued From page 8 Interview on 8/2/12 at 3:30 PM with Administrative Nursing Staff member # 1 revealed it would be her expectation staff would remove dirty gloves, wash their hands, and put on a clean pair of gloves before proceeding with their tasks. Interview confirmed aide #4 went from dirty to clean and that would be considered cross contamination. 2. The facility Perineal / Incontinent Care protocol dated 2/12/12 for a female resident was reviewed. The policy included: -When procedure has been completed, REMOVE GLOVES, clean up at bedside, wash hands and make sure the resident is dry and repositioned safely before exiting room with call bell in place. -Dispose of linens and soiled materials per facility policy. Re-wash hands. In continent care was observed on Resident #17 on 8/1/12 at 4:40 PM. The resident was provided care by Nursing Assistant (NA) #1. When NA #1 completed incontinent care she disposed of the wipe and brief and rearranged the resident's covers, NA #1 then pushed the clean unused disposable wipes extending from the box back into the box and closed the lid. NA #1 did not remove her soiled gloves prior to placing the clean wipes back into the wipe container or before replacing the resident's cover. The NA was observed to remove the soiled gloves just prior to leaving the room. The NA was not observed washing her hands. An interview was conducted with NA#1 after she provided incontinent care on Resident #13. She stated she should have removed her gloves and	F 441	**F 441** **4. The following monitoring initiative will be put in place to ensure that the corrective action is achieved and maintained:** One episode of pericare will be observed by the DON or designee five times weekly for three weeks. At least one observed episode will be on second and third shifts. Then one episode of pericare will be observed by the DON or designee three times weekly for three weeks; again including an observation on both second and third shifts. Then two episodes of pericare will be observed by the DON or designee for three weeks including all shifts. Results of the observations will be reported to the QA committee which will determine revisions to the plan and ongoing monitoring schedule. This QA initiative will become part of the QA program.	8-30-12

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F 441	Continued From page 9 washed her hands prior to replacing the resident covers and before putting the wipes back into the box. An interview was conducted with Nursing Administrative staff #1 on 8/2/12 at 10:49 AM. She stated direct care staff are in-serviced yearly on incontinent care. Staff are checked off on skills and are given a copy of the facility Incontinent Care Policy. She indicated the facility had done an in-service last month on incontinent care. The Nursing Administrative staff member #1 revealed it was her expectation that direct care staff would follow the facility policy and provide incontinent care in a sanitary manner.	F 441		

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	345523	A. BUILDING 01 - MAIN BUILDING B. WING _____ SEP 20 2012	08/29/2012

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K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: A. Basedon observation on 08/29/2012 the door to the soiled linen room and the door to the soiled utility room located near the long term care nurses ststion (used to store soiled linen)failed to close and latch.	K 029	**Submission of this response to the statement of deficiencies does not constitute an admission that the deficiencies exist and/or were correctly cited or required correction.** **K029** **1. The following corrective action was accomplished to correct the practice:** The doors to the soiled utility room and the soiled linen room located near the long term care nurses station were repaired so that they close and latch properly.	10-13-12
K 061 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1 This STANDARD is not met as evidenced by: A. Based on observation on 08/29/2012 the accelerators on the dry sprinkler systems each have two (2) valves that are not electrically supervised.	K 061	**2. The following was accomplished to ensure that other life safety issues having the potential to affect residents by the same practice:** All doors in the facility were audited to ensure proper closing and latching.	10-13-12

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

Christine Plaumess — Administrator — 9-14-12

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.

CD

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
	345523	A. BUILDING 01 - MAIN BUILDING B. WING _____	08/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/RAMSEUR	7166 JORDON ROAD RAMSEUR, NC 27316

(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 061 K 062 SS=D	Continued From page 1 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: A. Based on documentation on 08/29/2012 the dry sprinkler systems failed to meet the sixty (60) second water flow requirement. 42 CFR 483.70 (a)	K 061 K 062	**3. The following measures will be put into place to ensure that the practice does not recur:** Five random resident room doors on each hall and the soiled utility room and linen room doors as well as 3 nonresident room doors will be audited weekly for 4 weeks by the Director of Maintenance or his designee to ensure proper closing and latching. Thereafter, the same quality audit of 25 doors will be done monthly. **4. The following quality audit will be put in place to ensure that the corrective action will not recur and will become part of the quality assurance program:** Five random resident room doors, the soiled utility and linen room doors, and 3 nonresident room doors will be audited weekly for four weeks to ensure that the doors close and latch properly. The results of this audit will be brought to the QAA Committee for evaluation. Corrective action and audits will be revised as needed.	10-13-12

K 061 10-13-12

1. The following will be accomplished to correct the practice:

The facility's contracted sprinkler company will install electronic supervisory devices on the two valves of the accelerators on the dry sprinkler system. The facility's fire alarm system provider will integrate these supervisory devices into the alarm system so that a local alarm will sound if the valves are closed.

2. The following will be accomplished to identify other life safety issues having the potential to affect residents by the same practice:

All other valves which require supervision on the dry sprinkler system are supervised and in compliance.

3. The following measures will be put into place to ensure that the practice does not recur: 10-13-12

The Director of Maintenance will check the electronic supervisory devices weekly for four weeks and then monthly thereafter to ensure that they are in proper working order.

4. The following will be put in place to ensure that the corrective action will monitored and become part of the Quality Assurance Program:

The results of the audit will be brought to the Quality Assurance Committee for evaluation and revision as needed.

K 062 10-13-12

1. The following will be accomplished to correct the practice:

The facility's contracted sprinkler service provider will conduct a flow inspection test and the lines will be flushed to ensure the flow requirement is met.

10-13-12

2. The following action will be taken to identify other life safety issues having the potential to affect residents by the same practice:

The entire sprinkler system will be inspected by the facility's contracted sprinkler service to ensure that it meets the requirements. Repairs and adjustments to the system will be done as needed.

3. The following measure will be put into place to ensure that the practice does not recur:

Flow tests will be conducted quarterly during quarterly sprinkler inspection conducted by the facility's contracted sprinkler service.

4. The following monitoring system will be put in place and become part of the facility's quality assurance program:

Results of the initial flow inspection testing and the quarterly flow tests will be brought to the Quality Assurance

Committee for review and evaluation. Changes to the corrective action plan or monitoring system will be accomplished as needed as determined by the Quality Assurance Committee.

10-13-12