STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345541	A. BUILDING _____ B. WING _____	C 11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLDE KNOX COMMONS AT THE VILLAGES OF MECKLENBURG	13825 HUNTON LANE HUNTERSVILLE, NC 28078

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and medical record review the facility failed to implement a bed/chair alarm per physician's order for a resident who fell for 1 of 3 sampled residents reviewed with a history of falls. (Resident #100) The findings included: Resident #100 was admitted to the facility on 05/16/12. Diagnoses included personal history of falls, dementia with behaviors, depression, and osteoarthritis. A fall risk assessment dated 02/06/15 assessed Resident #100 with a total score of 10 (high risk for falls) due to intermittent confusion, balance problems while walking, medication (antidepressant), a history of falls and predisposing diagnoses (dementia). A physician's order dated 08/09/15 recorded that Resident #100 would have a bed and chair alarm in place and the alarms would be checked for placement and function each shift.	F 323	THIS FACILITY□S RESPONSE TO THIS REPORT OF SURVEY DOES NOT DENOTE AGREEMENT WITH THE STATEMENT OF DEFICIENCIES; NOR DOES IT CONSTITUTE AN ADMISSION THAT ANY STATED DEFICIENCY IS ACCURATE. WE ARE FILING THE POC BECAUSE IT IS REQUIRED BY LAW. F323 □ 483.25(h) Free Of Accident Hazards/Supervision/Devices ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident #100 did have an bed alarm in place during the survey process however she has been re-evaluated by the Safety Committee to determine if the current intervention/s are appropriate. The bed alarm pad has been removed and new interventions have been put into place. The resident has been placed on a toileting program, a anti-skid mat has	12/18/15

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

Electronically Signed | 12/17/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 1 A quarterly minimum data set assessment dated 10/28/15, assessed Resident #100 with impaired cognition, required supervision with ambulation due to unsteady balance with transitions and walking, use of a walker for ambulation and sustained 2 falls without injury since the last assessment. A care plan updated on 10/28/15 identified Resident #100 was at risk for falls due to daily use of an antidepressant and unsteady gait. Interventions included stand by assistant with ambulation and use of a rolling walker due to shuffled gait at times, call bell in reach, assist with all transfers, and bed/chair alarms at all times, staff to check each shift. Review of nurse's notes and incident reports revealed Resident #100 sustained the following falls with no indication that a bed/chair alarm was in place at the time of the fall: 10/20/15, Resident #100 was found on the floor in her room by staff at 2 PM. Her bed was in a low position and bed rails were down. Resident #100 fell while trying to get in bed, using a rollator walker, she lost her balance while ambulating to sit on her bed; she slid to floor. She was assessed without injury. She was reminded to request assistance with ambulation. 11/14/15, Resident #100 was found seated on the floor in her room by staff at 4 PM. She ambulated without assistance or the use of her rollator walker and fell. She complained of pain to her left hand, left wrist and left forearm. Xray results were negative for a fracture. She was medicated for pain with effective results. She was referred to therapy.	F 323	been placed at her bedside to prevent resident's feet from sliding when attempting to get out of bed. The resident will be assisted to bed after lunch and before dinner as determined by her patterns of getting in and out of bed. ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: The DON, and Designee reviewed all residents physician's orders to ensure that all resident's with personal alarms and other interventions are in place and appropriate. A QA Form that has the resident's name, if they had a physician's order, if the resident had a order then was the personal alarm or intervention in place was used and they signed off on the form. There were no discrepancies found between the physician's orders and the interventions. All devices were in place and in working order. In the future to ensure that all alarms are in place and in working order the facility will utilize a "alarm clock sticker" that will be added to the already existing symbol communication system/device on the outside of the resident's room to indicate who has a personal body alarm. All resident□s and family members are notified of this symbol communication system/device upon admission to the facility. Consent from the resident/family member is obtained at admission and	

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F 323	Continued From page 2 Resident #100 was observed in bed on 11/19/15 at 9:51 AM, 11/19/15 at 11:33 AM and 11/19/15 at 2:25 PM with the alarm cord for a personal bed alarm lying on the floor, detached from the alarm box. An interview with nurse aide #1 (NA #1) occurred on 11/19/2015 at 2:25 PM. NA #1 stated in interview that she was a routine NA for Resident #100. NA #1 stated Resident #100 was independent with toileting, routinely took herself to the bathroom using a rollator walker and transferred herself in/out of bed and on/off the toilet. NA #1 stated she rounded on Resident #100 throughout the shift and was aware that the Resident had been back/forth to the bathroom that day during the 7AM - 3PM shift. NA #1 stated that Resident #100 should be supervised with transfers due to her high risk for falls so that staff could remind her to use her rollator walker. During the interview, Resident #100 was observed in bed with the alarm cord detached from the alarm box and hanging on the floor. NA #1 stated the alarm cord should have been attached to the alarm box, she tried to remember to check the alarm when she rounded on Resident #100, but she did not realize the cord was not attached. NA #1 further stated that the clip to the alarm cord was broken and could be the reason the alarm cord did not fit securely into the alarm box. An interview was conducted on 11/20/15 at 10:44 AM with the nurse supervisor. The nurse supervisor stated she expected nurses and nurse aides to round on their assigned residents throughout the shift to ensure alarms were in place. The nurse supervisor stated that if the clip to an alarm cord was broken causing the alarm	F 323	consent document is kept in the resident admission file. They will conduct QA rounds on a daily basis for one (1) month, weekly basis for one (1) month and monthly for three (3) months by utilizing the housekeeping staff. The housekeeping staff will be in-serviced by the DON and Nurse Manager by December 18, 2015 on how to recognize who has a personal alarm and if it is in working order as well as who to report to if the alarm is not in place or appears to not be working properly. The Nursing staff will be responsible to secure a new alarm and put it into place. The Housekeeping staff will document on their daily assignment sheets that they observed the personal body alarm and it was in working order. In addition the Nursing staff will be in-serviced by December 18, 2015 on proper placement and function checks on all alarming devices and where and how to replace an alarm that is not functioning properly. This will include the use of a Communication Notebook which will be kept at each Nurses' station that will be updated by the Medical Records Nurse weekly and Nurse Managers as needed that includes all residents who have alarms. The Nursing staff will be responsible to review this communication book each shift to determine which residents have assistive devices. All Nurses will document on all residents who have alarming devices on their Treatment Administration Record (TAR) every shift that devices were properly placed and	

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F 323	Continued From page 3 cord not to stay attached to the alarm box, the cord should be replaced. An interview occurred on 11/20/15 at 11:59 AM with NA #2 and revealed she typically worked with Resident #100 on the 3PM - 11PM shift. NA #2 stated that Resident #100 ambulated to the bathroom independently, but at times required minimal help with toileting. NA #2 stated she was the assigned NA for Resident #100 when she fell in October 2015. NA #2 stated Resident #100 was using the bathroom, forgot her walker and fell. NA #2 stated she was not in the room when Resident #100 fell, but NA #2 saw Resident #100 on the floor in her room and told the nurse. NA #2 stated she was not aware if Resident #100 had an alarm. NA #2 stated she did not check placement for an alarm on Resident #100 during the shift when the Resident fell because the supervisors usually checked to make sure alarms were in place and working. NA #2 stated that since Resident #100 ambulated in her room with her walker going back and forth to the bathroom she would not check for an alarm during the day, but would check for an alarm before the Resident went to bed, so that the Resident could take herself to the bathroom during the day. An interview occurred with nurse #1 on 11/19/15 at 3:07 PM. Nurse #1 stated Resident #100 was at high risk for falls due to her non-compliance with calling for assistance, unsteady gait, shuffling her feet when ambulating, impaired cognition and history of falls. Nurse #1 stated he rounded on Resident #100 that morning (11/19/15) at 8:30 AM and her bed alarm was intact. Nurse #1 stated he monitored the Resident each shift for the placement of her alarm, but Resident #100 had a history of playing with cords and he was not	F 323	functional. The Housekeeping Supervisor and/or Maintenance Director will be responsible to do a QA on a weekly basis for three (3) months to ensure that all personal body alarms are in place and in working order. They will document this on a QA Form that indicates the above information. The form will be given to the QA Committee on a weekly basis who will review to determine if interventions in place are appropriate and effective. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT REOCCUR: In the future to ensure that all alarms are in place and in working order the facility will utilize a "alarm clock sticker" that will be added to the already existing symbol communication system/device on the outside of the resident's room to indicate who has a personal body alarm. All resident□s and family members are notified of this symbol communication system/device upon admission to the facility. Consent from the resident/family member is obtained at admission and consent document is kept in the resident admission file. They will conduct QA rounds on a daily basis for one (1) month, weekly basis for one (1) month and monthly for three (3) months by utilizing the housekeeping staff. The housekeeping staff will be in-serviced by the DON and Nurse Manager by December 18, 2015 on how to recognize	

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F 323	Continued From page 4 aware that the bed alarm had not been in place while she was in bed that day. Nurse #1 stated that when Resident #100 fell in October 2015, a staff member informed him of the fall, but he did not know if an alarm was in place and sounded at the time of the fall because his nurse's note did not indicate the status of the alarm. An interview was conducted on 11/20/15 at 3:29 PM with the director of nursing (DON). The DON stated that when a fall occurred, the nurse was responsible for completing a head to toe assessment of the resident, an incident report, a nurse's progress note and contacting the family/physician. The DON reviewed the incident report and the nurse's progress note, administrative staff discussed the fall and implemented any further interventions needed to try and prevent further falls. The DON stated she did not require nurses to document the use of an alarm at the time of a fall and could not say whether or not the alarm was in use for Resident #100 when she fell in October/November 2015. The DON stated that Resident #100 had a physician's order for an alarm and she expected the alarm to be used per the physician's order, staff monitoring to ensure the alarm was in place and functioning, and staff monitoring residents for their activity and needs.	F 323	who has a personal alarm and if it is in working order as well as who to report to if the alarm is not in place or appears to not be working properly. The Nursing staff will be responsible to secure a new alarm and put it into place. The Housekeeping staff will document on their daily assignment sheets that they observed the personal body alarm and it was in working order. These records will be given to the Housekeeping Supervisor who will present them to the QA Committee weekly. The Nursing staff will be in-serviced by December 18, 2015 on proper placement and function checks on all alarming devices. This will include the use of a Communication Notebook which will be kept at each Nurses' station that will be updated by the Medical Records Nurse weekly and Nurse Managers as needed that includes all residents who have alarms. The Nursing staff will be responsible to review this communication book each shift to determine which residents have assistive devices. The CNA's will be responsible to sign a log stating they have reviewed the Communication book every shift. All Nurses will document on all residents who have alarming devices on their Treatment Administration Record (TAR) every shift that devices were properly placed and functional. INDICATE HOW THE FACILITY PLANS TO MONITOR IT□S PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE	

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F 323	Continued From page 5	F 323	SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE POC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY: In the future to ensure that all alarms are in place and in working order the facility will utilize a "alarm clock sticker" that will be added to the already existing symbol communication system/device on the outside of the resident's room to indicate who has a personal body alarm. All resident□s and family members are notified of this symbol communication system/device upon admission to the facility. Consent from the resident/family member is obtained at admission and consent document is kept in the resident admission file. QA rounds will be conducted on a daily basis for one (1) month, weekly basis for one (1) month and monthly for three (3) months by utilizing the housekeeping staff. The Nursing staff will be responsible to review this communication book each shift to determine which residents have assistive devices. The CNA's will be responsible to sign a log stating they have reviewed the Communication book every shift. All Nurses will document on all residents who have alarming devices on their Treatment Administration Record (TAR) every shift that devices were properly placed and	

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F 323	Continued From page 6	F 323	functional. The Housekeeping Supervisor and/or Maintenance Director will be responsible to do a QA round on a weekly basis for three (3) months to ensure that all personal body alarms are in place and in working order. They will document this on a QA Form that indicates the above information. The form will be given to the Administrator who will present the information to the QA Committee on a weekly basis. The QA Committee will review the information to determine if interventions in place are appropriate and effective. If not then new interventions will be determined and implemented at that time. The QA Committee will review the systemic changes to ensure the facility□s progress towards implementation of corrective action(s) and the facility□s performance, to ensure that corrective performance is achieved and sustained. The QA Committee will review the facility□s progress monthly for effectiveness and revise or develop new measures as necessary to ensure that corrective action is integrated and the system is sustained or revised as needed to achieve and maintain corrective solutions.	
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of	F 520		12/18/15

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F 520	Continued From page 7 nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and medical record review the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions the committee put into place in April of 2015. This was for one recited deficiency which was originally cited in March of 2015 on a complaint investigation survey and subsequently recited in November 2015 on a current recertification survey. The deficiency was in the area of accidents. The continued failure of the facility during a complaint investigation survey and a recent recertification survey shows a pattern of the facility's inability to sustain an effective Quality Assurance Program.	F 520	THIS FACILITY□S RESPONSE TO THIS REPORT OF SURVEY DOES NOT DENOTE AGREEMENT WITH THE STATEMENT OF DEFICIENCIES; NOR DOES IT CONSTITUTE AN ADMISSION THAT ANY STATED DEFICIENCY IS ACCURATE. WE ARE FILING THE POC BECAUSE IT IS REQUIRED BY LAW. F520 □ 483.75 (o)(1) QAA Committee - Members/Meet Quarterly/Plans ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT	

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F 520	Continued From page 8 Findings included: This tag is cross referenced to: F 323 - Accidents. Based on observations, staff interviews and medical record review the facility failed to implement a bed/chair alarm per physician's order for a resident who fell for 1 of 3 sampled residents reviewed with a history of falls. (Resident #100) The facility was originally cited for F 323 during the March 2015 complaint investigation survey for failing to implement fall precautions for a resident at risk for falls that fell and sustained a fractured femur for 1 of 3 sampled residents. (Resident #1) An interview with the administrator on 11/20/15 at 5:45 pm revealed that he attributed a recitation in the area of accidents to a breakdown in communication between facility staff. He stated staff should have been monitoring resident falls. He stated he would have a meeting with the Director of Nursing to re- evaluate their process for monitoring falls and identify the problem.	F 520	PRACTICE: Resident #100 did have an bed alarm in place during the survey process however she has been re-evaluated by the Safety Committee to determine if the current intervention/s are appropriate. The bed alarm pad has been removed and new interventions have been put into place. The resident has been placed on a toileting program, a anti-skid mat has been placed at her bedside to prevent resident's feet from sliding when attempting to get out of bed. The resident will be assisted to bed after lunch and before dinner as determined by her patterns of getting in and out of bed. ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: The DON, and Designee reviewed all residents physician's orders to ensure that all resident's with personal alarms and other interventions are in place and appropriate. A QA Form that has the resident's name, if they had a physician's order, if the resident had a order then was the personal alarm or intervention in place was used and they signed off on the form. There were no discrepancies found between the physician's orders and the interventions. All devices were in place and in working order. In the future to ensure that all alarms are	

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F 520	Continued From page 9	F 520	in place and in working order the facility will utilize a "alarm clock sticker" that will be added to the already existing symbol communication system/device on the outside of the resident's room to indicate who has a personal body alarm. All resident□s and family members are notified of this symbol communication system/device upon admission to the facility. Consent from the resident/family member is obtained at admission and consent document is kept in the resident admission file. They will conduct QA rounds on a daily basis for one (1) month, weekly basis for one (1) month and monthly for three (3) months by utilizing the housekeeping staff. The housekeeping staff will be in-serviced by the DON and Nurse Manager by December 18, 2015 on how to recognize who has a personal alarm and if it is in working order as well as who to report to if the alarm is not in place or appears to not be working properly. The Nursing staff will be responsible to secure a new alarm and put it into place. The Housekeeping staff will document on their daily assignment sheets that they observed the personal body alarm and it was in working order. In addition the Nursing staff will be in-serviced by December 18, 2015 on proper placement and function checks on all alarming devices and where and how to replace an alarm that is not functioning properly. This will include the use of a Communication Notebook which will be kept at each Nurses' station that will be	

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F 520	Continued From page 10	F 520	updated by the Medical Records Nurse weekly and Nurse Managers as needed that includes all residents who have alarms. The Nursing staff will be responsible to review this communication book each shift to determine which residents have assistive devices. All Nurses will document on all residents who have alarming devices on their Treatment Administration Record (TAR) every shift that devices were properly placed and functional. The Housekeeping Supervisor and/or Maintenance Director will be responsible to do a QA on a weekly basis for three (3) months to ensure that all personal body alarms are in place and in working order. They will document this on a QA Form that indicates the above information. The form will be given to the QA Committee on a weekly basis who will review to determine if interventions in place are appropriate and effective. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT REOCCUR: In the future to ensure that all alarms are in place and in working order the facility will utilize a "alarm clock sticker" that will be added to the already existing symbol communication system/device on the outside of the resident's room to indicate who has a personal body alarm. All resident□s and family members are notified of this symbol communication system/device upon admission to the	

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	345541	A. BUILDING _____ B. WING _____	C 11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLDE KNOX COMMONS AT THE VILLAGES OF MECKLENBURG	13825 HUNTON LANE HUNTERSVILLE, NC 28078

(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 520	Continued From page 11	F 520	facility. Consent from the resident/family member is obtained at admission and consent document is kept in the resident admission file. They will conduct QA rounds on a daily basis for one (1) month, weekly basis for one (1) month and monthly for three (3) months by utilizing the housekeeping staff. The housekeeping staff will be in-serviced by the DON and Nurse Manager by December 18, 2015 on how to recognize who has a personal alarm and if it is in working order as well as who to report to if the alarm is not in place or appears to not be working properly. The Nursing staff will be responsible to secure a new alarm and put it into place. The Housekeeping staff will document on their daily assignment sheets that they observed the personal body alarm and it was in working order. These records will be given to the Housekeeping Supervisor who will present them to the QA Committee weekly. The Nursing staff will be in-serviced by December 18, 2015 on proper placement and function checks on all alarming devices. This will include the use of a Communication Notebook which will be kept at each Nurses' station that will be updated by the Medical Records Nurse weekly and Nurse Managers as needed that includes all residents who have alarms. The Nursing staff will be responsible to review this communication book each shift to determine which residents have assistive devices. The CNA's will be responsible to sign a log	

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F 520	Continued From page 12	F 520	stating they have reviewed the Communication book every shift. All Nurses will document on all residents who have alarming devices on their Treatment Administration Record (TAR) every shift that devices were properly placed and functional. INDICATE HOW THE FACILITY PLANS TO MONITOR IT□S PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE POC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY: In the future to ensure that all alarms are in place and in working order the facility will utilize a "alarm clock sticker" that will be added to the already existing symbol communication system/device on the outside of the resident's room to indicate who has a personal body alarm. All resident□s and family members are notified of this symbol communication system/device upon admission to the facility. Consent from the resident/family member is obtained at admission and consent document is kept in the resident admission file. QA rounds will be conducted on a daily basis for one (1) month, weekly basis for one (1) month and monthly for three (3) months by	

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F 520	Continued From page 13	F 520	utilizing the housekeeping staff. The Nursing staff will be responsible to review this communication book each shift to determine which residents have assistive devices. The CNA's will be responsible to sign a log stating they have reviewed the Communication book every shift. All Nurses will document on all residents who have alarming devices on their Treatment Administration Record (TAR) every shift that devices were properly placed and functional. The Housekeeping Supervisor and/or Maintenance Director will be responsible to do a QA round on a weekly basis for three (3) months to ensure that all personal body alarms are in place and in working order. They will document this on a QA Form that indicates the above information. The form will be given to the Administrator who will present the information to the QA Committee on a weekly basis. The QA Committee will review the systemic changes to ensure the facility□s progress towards implementation of corrective action(s) and the facility□s performance, to ensure that corrective performance is achieved and sustained. The QA Committee will review the facility□s progress monthly for effectiveness and revise or develop new measures as necessary to ensure that corrective action is integrated and the system is sustained or revised as needed to achieve and maintain corrective solutions. The VP of Operations or other Corporate staff member will review the results of the interventions on a monthly	

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F 520	Continued From page 14	F 520	basis and will attend the QA Committee on a quarterly basis and will review the information to determine if interventions in place are appropriate and effective and are being sustained. If not then new interventions will be determined and implemented at that time	