STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355076	A. BUILDING _____ B. WING _____	07/31/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHWOOD DEACONESS HEALTH CNT	4 N PARK ST NORTHWOOD, ND 58267

(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 For the standard Medicare/Medicaid recertification survey started on 07/28/14 and completed on 07/31/14, the sample included two (2) residents for complete review, eight (8) residents for focused review, and one (1) closed record for review.	F 000		
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.	F 278		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: CEO | (X6) DATE: 8-25-14

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 278	Continued From page 1 This REQUIREMENT is not met as evidenced by: MINIMUM DATA SET - URINARY TOILETING PROGRAM 1. Based on observation, record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), and staff interview, the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the residents' status for 6 of 7 sampled residents (Resident #1, #4, #6, #8, #9, and #10) identified as on a current urinary toileting program. Failure to accurately code this portion of the MDS did not provide an accurate assessment of these residents' current status and needs. Findings include: The Long-Term Care Facility RAI User's Manual, October 2013, Chapter 2, page 2-1 states, ". . . The Resident Assessment Instrument (RAI) process is the basis for the accurate assessment of each nursing home resident . . ." Chapter 3, page H-5 states, ". . . Look for documentation in the medical record showing that the following three requirements have been met: * implementation of of an individualized, resident specific toileting program that was based on an assessment of the resident's unique voiding pattern * evidence that the individualized program was communicated to staff and the resident (as appropriate) verbally and through a care plan, flow records, and a written report * notations of the resident's response to the toileting program and subsequent evaluations, as needed."	F 278	F278: Residents #1, #4, #8, #9, and #10 will no longer be coded on the MDS assessment as a urinary toileting program. Modifications to the most recent MDS assessment will be completed and submitted by August 28, 2014 and billing adjustments will be made accordingly. For resident #6, the urinary toileting plan will be reevaluated and modified to meet this resident's individual needs (see attached care plan). Modifications to the most recent MDS assessment for resident #6 will be completed and submitted by August 28, 2014 and billing adjustments will be made accordingly. All other residents now on toileting programs will have MDS assessments modified and submitted by August 28, 2014 and billing adjustments will be made accordingly. MDS nursing staff will review RAI manual October 2013, chapter 2, page 2-1 and chapter 3 page H-5 (see attached signature of review). MDS Nursing Staff will also attend the "MS 3.0: Understanding Coding and Scheduling Requirements Day One" on September 16, 2014 presented by Ron Orth at the NDLTCA Fall Conference (see attached conference brochure and registrations). Nursing and CNA staff will be educated on following toileting plans and how to communicate when modifications to toileting plans are needed by August 29, 2014. Resident #6 will not be coded as being on a toileting program. Telephone call per Nancy Carlson, APRN 9/18/14	

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F 278	Continued From page 2 Chapter 3, page H-6 states, ". . . Toileting (or trial toileting) programs refer to a specific approach that is organized, planned, documented, monitored, and evaluated that is consistent with the nursing home's policies and procedures and current standards of practice . . ." Chapter 3, page Z-6 states, ". . . The importance of accurately completing and submitting the MDS cannot be overemphasized. The MDS is the basis for the development of: * the development of an individualized care plan * the Medicare Prospective Payment System * Medicaid reimbursement programs * quality monitoring activities . . . * the data-driven survey and certification process * the quality measures used for public reporting * research and policy development." - The generic toileting schedules, established for Resident #1, #4, #8, #9, and #10, failed to meet the criteria for coding a urinary toileting program (item H0200C) on the MDS. The toileting programs lacked individualized times based on each residents' unique voiding pattern, as evidenced by: * Review of Resident #1's medical record occurred on July 29-30, 2014. The quarterly MDS, dated 06/09/14, identified the resident as sometimes able to make self understood, rarely able to understand others, requiring extensive assistance of two or more staff members for toileting, frequently incontinent of urine, and on a urinary toileting program. Resident #1's current care plan stated, "Problem . . . incontinent of bowel and bladder at times with some continent episodes . . . Approach . . .	F 278	QA data will be collected monthly prior to submission of MDS assessment by MDS coordinator evaluating residents' toileting programs meeting the criteria to qualify for toileting program on MDS per RAI manual requirement. This data will be reported to QA & I Committee monthly until compliance is determined (see attached QA & I monitoring form). consistently at 100%. QA data collection to start August 28th, 2014. Residents #1, #3, #4, #6, #7, #8, #9, and #10 most recent MDS assessment signatures for sections A and Z will be modified to reflect the individual staff member who completed the section of the MDS by August 28, 2014. For all other residents updated software is now in place that will only allow the person completing the specific sections of the MDS to sign that section. Each member of the care plan team will review the attestation statement (20400) as identified in Chapter 3, Z-6 of the RAI manual (see attached signatures of review). QA data will be collected by MDS Coordinator monthly prior to submission of MDS assessments to ensure accuracy of signatures for sections A and Z of MDS assessment. Data will be reported to the QA & I Committee monthly until compliance is determined (see attached QA & I monitoring form). Consistently at 100%. QA data collection to start August 28th, 2014.	telephone call per Nancy Carlson, DON/HIC 8/27/14 09/04/14 telephone call per Nancy Carlson, DON/HIC 8/27/14

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F 278	Continued From page 3	F 278		

attempt to toilet when getting up in the AM [morning], before dinner, before supper, at hs [before sleep, at bedtime], and on first rounds at night and prn [as needed] . . ."

* Review of Resident #4's medical record occurred on July 29-30, 2014. The quarterly MDS, dated 06/02/14, identified the resident as able to make self understood, able to understand others, requiring total assistance of two or more staff members for toileting, continent of urine, and on a urinary toileting program.

Resident #4's current care plan stated, "Problem. I am continent of bowel and bladder and I am on a toilet schedule . . . Approach . . . transfer to the toilet with the use of the EZ [mechanical] lift when getting up in am, after dinner, before supper, @ hs and prn as she requests . . ."

* Review of Resident #8's medical record occurred on July 30-31, 2014. The quarterly MDS, dated 07/06/14, identified severe cognitive impairment, extensive assistance from one person for transfers and toileting, a current toileting program, and frequent urinary incontinence.

The resident's current care plan stated, ". . . Cue and assist me to toilet as before when I first arise in AM and every 2-3 hours during day - also when I get restless or am awake at night. . . ."

* Review of Resident #9's medical record occurred on July 30-31, 2014. The significant change MDS, dated 06/03/14, identified severe cognitive impairment, extensive assistance from one person for toilet use, a current urinary toileting program, and frequent urinary

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F 278	Continued From page 4	F 278		

incontinence.

The resident's current care plan stated, ". . . Cue and assist me to bathroom when I first get up and every 2-3 hours or more often if restless or if I am up at night . . ."

* Review of Resident #10's medical record occurred on 07/30/14. The quarterly MDS, dated 07/03/14, identified the resident as usually able to make self understood, able to understand others, requiring extensive assistance of two or more staff members for toileting, frequently incontinent of urine, and on a urinary toileting program.

Resident #10's current care plan stated, "Problem . . . infrequent episodes of bladder incontinence . . . Approach . . . offer to assist her to the toilet when getting up in the a.m., after meals, at hs, and on first and third rounds during the night and prn as she requests . . ."

- Review of Resident #6's medical record occurred on July 28-30, 2014. The quarterly MDS, dated 07/10/14, identified the resident as sometimes understood, usually understands others, extensive assistance from two or more staff members for transfers and toileting, a urinary toileting program, and frequent urinary incontinence.

Resident #6's current care plan stated, ". . . toilet when getting up in the am, at 10:30 am or 11 am, after dinner, 4 pm . . ."

During an interview on 07/29/14 at 5:12 p.m., a certified nursing assistant (CNA) (#4) stated Resident #6 used the bathroom "around 3 [p.m.]," the resident was incontinent of urine, did not void,

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F 278	Continued From page 5 and is "usually wet when we get her up at 3." The CNA also stated Resident #6 can usually let the staff know when she needs to use the bathroom, as the resident will become more agitated. Observation on 07/30/14 at 3:23 p.m. showed two CNAs (#5 and #6) assisted Resident #6 to the bathroom. The resident was incontinent of urine and did not void. A CNA (#6) stated, "I think she does [have scheduled toileting times], it's listed on her care card. But she can tell us when she has to go. She'll start pointing [to the bathroom]." Observation and staff interview showed Resident #6 was able to indicate a need to toilet, and staff failed to follow the specific toileting schedule established for Resident #6. Therefore, the facility failed to meet the criteria for coding a urinary toileting program on the MDS. During an interview, on the morning of 07/30/14, two administrative nursing staff members (#1 and #2) verified the facility staff failed to accurately complete item H0200C on the MDS. MINIMUM DATA SET - ITEM Z0400 (ATTESTATION STATEMENT) 2. Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), and staff interview, the facility staff failed to ensure each individual staff member who completed a portion of the Minimum Data Set (MDS) assessment accurately identified the section(s) or portion(s) they completed for 8 of 10 sampled residents (Resident #1, #3, #4, #6, #7, #8, #9, and #10). Legally, item Z0400 is an attestation of accuracy with the primary	F 278		

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F 278	Continued From page 6 responsibility for its accuracy with the person selecting the MDS item response. Findings include: The Long-Term Care Facility RAI User's Manual, October 2013, Chapter 3, page Z-6 states, ". . . The importance of accurately completing and submitting the MDS cannot be overemphasized." Each person completing a section of the MDS is required to sign the attestation statement (Z0400) as identified on page Z-6 that reads, "I certify that the accompanying information accurately reflects resident assessment information for this resident . . . I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care . . ." Page Z-7 states, ". . . All staff who completed any part of the MDS must enter their signatures, titles, sections or portion(s) of section(s) they completed, and the date completed . . . Two or more staff members can complete items within the same section of the MDS. When filling in the information for Z0400 (attestation statement of accuracy), any staff member who has completed a subset of item within a section should identify which item(s) he/she completed within that section . . ." - Record review for Resident #1, #3, #4, #6, #7, #8, #9, and #10 occurred between July 28th and July 31st of 2014. Review of the current MDSs revealed the facility staff failed to ensure that each individual staff member who completed a portion of the MDS assessment, accurately identified the section(s) or portion(s) they completed; as the attestation statements (item Z0400) showed two staff members completed some of the exact same sections (i.e. sections A and Z) as evidenced by:	F 278		

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F 278	Continued From page 7 * Resident #1's MDS, dated 06/09/14, identified a licensed practical nurse (LPN) completed all items in Section A, and a licensed social worker (LSW) also completed all items in Section A. * Resident #3's MDS, dated 06/01/14, identified a registered nurse (RN) completed all items in Section A, and a LSW also completed all items in Section A. * Resident #4's MDS, dated 06/02/14, identified a LPN completed all items in Section A, and a LSW also completed all items in Section A. * Resident #6's MDS, dated 04/10/14, identified a LPN completed all items in Section A, and a LSW also completed all items in Section A. * Resident #7's MDS, dated 05/18/14, identified a RN completed all items in Section A, and a LSW also completed all items in Section A. * Resident #8's MDS, dated 07/06/14, identified a RN completed all items in Section A, and a LSW also completed all items in Section A. * Resident #9's MDS, dated 06/03/14, identified a RN completed all items in Section A, and a LSW also completed all items in Section A. * Resident #10's MDS, dated 07/03/14, identified a RN completed all items in Section Z, and a LPN also completed all items in Section Z. During an interview, on the morning of 07/30/14, two administrative nursing staff members (#1 and #2) verified the facility staff failed to accurately complete item Z0400 on the MDS.	F 278		

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F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure a drug regimen free from unnecessary medication for 1 of 5 sampled residents (Resident #7) receiving scheduled antianxiety medication. Failure to attempt a gradual dose reduction (GDR) (unless contraindicated) annually for antianxiety medications places residents at risk of receiving unnecessary medications and experiencing	F 329	F329: For resident #7 the attending physician and consulting pharmacist have been notified of need to evaluate anti-anxiety medication Clonazepam for gradual dose reduction. Dose reduction was ordered 07/30/2014 (see attached physician order). The attending physician dictated a progress note for resident #7 regarding regimen and dose reduction for Clonazepam (see attached note). For resident #7 and all other residents of the facility, Northwood Deaconess Health Center has reviewed and updated the Antipsychotic Drug Use and Gradual Dose Reduction Policy (see attached policy). Consulting pharmacist will be educated on Antipsychotic Drug Use and Gradual Dose Reduction Policy on August 28, 2014. All LTC nurses will be educated on the Antipsychotic Drug Use and Gradual Dose Reduction Policy by August 29, 2014 at staff meeting or one-on-one education with ADON or DON. The QA Data Collection Nurse will review monthly consulting pharmacist report for compliance with GDR protocol (see attached QA & I sheet). QA data will be brought to monthly QA & I meeting and monitored for compliance by the committee until compliance is determined. Consistently at 100%. QA data collection to start August 28, 2014. Telephone call per Nancy Carlson, DON HK 8/27/14	09/04/14

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F 329	Continued From page 9 adverse drug reactions related to these medications. Findings include: The facility failed to provide a policy specific to GDR for antianxiety medication upon request. Review of Resident #7's medical record occurred on July 27-30, 2014. Diagnoses included dementia, insomnia and depression. Physician orders included clonazepam 1 milligram daily at bedtime, initiated on 09/03/12. Resident #7's physician's progress notes over the past year lacked documentation to identify a contraindication for a GDR of clonazepam. During an interview at 10:00 a.m. on 07/30/14 with an administrative nurse (#2), she failed to provide any additional documentation regarding contraindications for a GDR for this resident. During an interview on the afternoon of 07/30/14, the medical director (#3) confirmed a GDR should have been addressed. Resident #7's record failed to identify a GDR attempt (or a clinical contraindication) of the clonazepam since the initiation of the medication on 09/03/12.	F 329		
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National	F 363		

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F 363	Continued From page 10 Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, review of facility menus, and staff interview, the facility failed to meet the nutritional needs of the residents by serving incorrect portion sizes during 3 of 3 observations of tray line (evening meal on 07/29/14, noon and evening meal on 07/30/14) in 3 of 3 dining rooms (Main, South Unit, and North Unit). Failure to follow recommended portion sizes as outlined in the facility's menus may result in weight changes and/or inadequate nutritional intake for all residents. Findings include: Review of the facility policy titled "Setting Up of Dining Room and Tray Service" occurred on 07/31/14. This policy, revised December 2004, stated, ". . . Food shall be placed on trays and plates with consideration for portion control, neatness, attractive appearance, and temperature control. . . . Proper serving utensils will be used to be consistent with the menu and/or diet order. . . ." Observation of tray line occurred on 07/29/14 during the evening meal. Observation showed the following inconsistencies between portion sizes listed on the facility's menus and the actual amount served to residents: Main dining room: *soup served with a 4 ounce (oz) ladle (residents received two ladles full of soup [a total	F 363	F363: The deficiency will be corrected by these measures being put into place: for all NDHC residents a scoop size policy has been put in to place to ensure proper portions are being served according to the menu and diet ordered. The staff will be educated on how to read the menus and what portion size to give at all meals. The portion sizes on the menu will have both the scoop # and the amount needed to be given. This will ensure no more further mistakes. Also, any scoop #, ladle or spoodle not needed will be taken out of all kitchens. We have already had an inservice on the deficiency and what the employees can expect with the changes. QA will be another measure started. Dietary manager/consulting dietician will do QA once a month and report to QA & I committee monthly with goal of 100% compliance. The QA will be making sure employees are using the right utensils to portion all meals and are reading the menus correctly. An inservice was given 8/11/14 to explain the deficiency and how we are going to coorect the deficiency. A follow up inservice will be held with QA data reviewed. QA will start the week of September 2, 2014. Scoop sizes will be added to menu immediately. Telephone call per Nancy Carlson, ODN/HK 8/27/14	09/04/14

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F 363	Continued From page 11 of 8 oz], the menu identified 6 oz) *carrots served with a 4 oz spoodle (residents received two spoodles full of carrots [a total of 8 oz], the menu identified 4 oz) North Unit dining room: *vegetable salad served with a 3 oz scoop (the menu identified 8 oz) *observation showed a staff member (#7) made egg salad sandwiches but did not measure the amount of egg salad used for each sandwich. The staff member served 9 of 10 residents in the dining room a half a sandwich. The menu identified 1 sandwich should be served to residents, and did not list a portion size for the egg salad. Although the staff member used a 6 oz ladle to serve soup, she stated she did not fill the soup ladle totally full because "it seemed like too much." South Unit dining room: *vegetable salad served with a 4 oz scoop (the menu identified 8 oz) *soup served with a 4 oz ladle (residents received two ladles full of soup [a total of 8 oz], the menu identified 6 oz) *carrots served with a 3 oz spoodle (the menu identified 4 oz) Observation of tray line occurred on 07/30/14 during the noon meal. Observation showed the following inconsistencies between portion sizes listed on the facility's menus and the actual amount served to residents: Main dining room: *Pureed carrots, country fried steak, and mashed potatoes all served with a 1/3 cup scoop (the menu identified 1/2 cup mashed potatoes,	F 363		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355076	A. BUILDING _____ B. WING _____	07/31/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 363	Continued From page 12 2/3 cup pureed steak, and 2/5 cup [a #10 scoop] of pureed carrots) North Unit dining room: *Mechanical soft country fried steak served with a 1/2 cup scoop (the menu identified 2/3 cup) Observation of tray line occurred on 07/30/14 during the evening meal. Observation showed the following inconsistencies between portion sizes listed on the facility's menus and the actual amount served to residents: Main dining room: *Chicken hotdish served with a 4 oz scoop (the menu identified 8 oz) South Unit dining room: *Pureed and regular texture chicken hotdish each served with a 4 oz scoop (the menu identified 8 oz for pureed and 8 oz for regular) During an interview on the morning of 07/31/14, a supervisory dietary staff member (#8) confirmed the portions served were incorrect, and staff should follow the portions listed on the menu.	F 363		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428		

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F 428	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on record review, facility policy review, and staff interview, the consulting pharmacist failed to identify and report a drug regimen irregularity regarding gradual dose reduction (GDR) to the attending physician and the director of nursing for 1 of 5 sampled residents (Resident #7) receiving antianxiety medication. Failure to suggest a GDR of clonazepam has the potential for the resident to receive unnecessary medication and experience adverse consequences related to the medication. Findings include: Review of the facility policy titled "Consulting Pharmacist Monthly Drug Review of Resident Drug Regime" occurred on 07/30/14. This policy, dated October 2009, stated, " . . . Review drug regimes of all residents and evaluate for any unnecessary medication. . . ." Review of Resident #7's medical record occurred on July 27-30, 2014. Diagnoses included dementia, insomnia and depression. Physician orders included the antianxiety medication clonazepam 1 milligram daily at bedtime, initiated on 09/03/12. The consulting pharmacist's monthly Medication Regimen Review (MRR) from June 2013 through June 2014 failed to address Resident #7's continued use of clonazepam. Each monthly MRR for this resident contained the entry stating, "No problems noted."	F 428	F428: For resident #7 the attending physician and consulting pharmacist were notified of the missed attempt to reduce the bedtime dose of Clonazepam and dose reduction was ordered on 07/30/2014 (see attached doctor's orders, see copy of attached doctor's note). For all other residents the policy "Monthly Drug Review" was updated to include antipsychotic medications, antidepressants, benzodiazepines, anti-anxiety medications, and sedataive medications (see attached policy). The consulting pharmacist will be educated on policy update no August 28, 2014 by the Director of Nursing. The LTC Unit Manager will develop a list of residents receiving antipsychotic medications, antidepressants, benzodiazepines, anti-anxiety medications, and sedative medications monthly to give to the consulting pharmacist prior to medication regimen reviews for focused review for need of gradual dose reduction (see attached GDR form). The consulting pharmacist will review all LTC residents' drug regimens monthly and will provide a report to the attending physician and the Director of Nursing that includes gradual dose reduction attempts needed or date completed (see policy "Format for Consulting Pharmacist").	

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F 428	Continued From page 14 During an interview at 10:00 a.m. on 07/30/14, an administrative nurse (#2) confirmed the facility failed to taper/attempt to taper Resident #7's clonazepam and failed to identify clinical contraindications for doing so.	F 428	The QA data collection nurse will review monthly consulting pharmacist report in comparison with facility list and will verify that all antipsychotic medications, antidepressants, benzodiazepines, anti-anxiety medications, and sedative medications have had GDR attempts and corresponding documentation completed per facility policy and will report findings to the QA & I Committee at their monthly meeting (see attached QA Data Collection Form) until compliance is determined. consistently at 10090. QA data collection to start August 28th, 2014. Telephone call per Nancy Carlson, DON/HK 8/27/14	09/04/14