Hawaii Dept. of Health, Office of Health Care Assuranc

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125020	A. BUILDING: _____ B. WING _____	06/09/2016

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON CARE CENTER - HONOLULU, LLC	1930 KAMEHAMEHA IV RD HONOLULU, HI 96819

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4 000	11-94.1 Initial Comments A state relicensure survey was conducted at the facility from 6/6 - 6/9/16. At the time of the entrance, the resident census was 95.	4 000		
4 105	11-94.1-22(g) Medical record system (g) All entries in a resident's record shall be: (1) Accurate and complete; (2) Legible and typed or written in black or blue ink; (3) Dated; (4) Authenticated by signature and title of the individual making the entry; and (5) Written completely without the use of abbreviations except for those abbreviations approved by a medial consultant or the medical doctor. This Statute is not met as evidenced by: Based on record reviews and interviews the facility failed to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized for 2 of 3 resident records reviewed for deaths in the Stage 2 survey. [redacted]	4 105	11-94. 1-22(g) Medical record system All entries in a resident's record shall be (1) Accurate and complete; (2) Legible and typed or written in black or blue ink; (3) Dated; (4) Authenticated by signature and title of the individual making the entry; and (5) Written completely without the use of abbreviations except for those abbreviations approved by a medial consultant or the medical doctor. I. Resident #26 and #186 are identified [redacted]. II. All residents have the potential to be affected. III. Staff education initiated on 6/25/16 and ongoing regarding the current facility policy on providing sufficient documentation of information in the clinical records by DON/ designee. Policy provided to surveyor was not the current facility policy at that time of the survey. Enclosed is the accurate policy which was and is being followed. The current policy does not contain a reference to the death certificate or post death documentation. IV. A chart audit to be done on all expired residents every month x2 months to ensure sufficient documentations are included in the clinical records as currently indicated on	7/08/16

Office of Health Care Assurance

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	7/7/16

[redacted]

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4 105	Continued From page 1 [redacted]	4 105	Continued from page 1 facility policy. Any issues identified will be recorded and reported monthly to the Quality Assurance Performance Improvement committee meeting. The QAPI committee will evaluate the effectiveness of the plan based on trend identified and implement additional interventions as needed to ensure continued compliance. The DON will oversee this process and will be in compliance by 7/08/16.	

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4 105	Continued From page 2	4 105		

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4 105	Continued From page 3 [redacted]	4 105		
4 115	11-94.1-27(4) Resident rights and facility practices Written policies regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family, legal guardian, surrogate, sponsoring agency or representative payee, and the public upon request. A facility must protect and promote the rights of each resident, including: (4) The right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility; This Statute is not met as evidenced by: Based on observation and interviews, the facility failed to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Finding includes: [redacted]	4 115	11-94. 1-27(4) Resident rights and facility practices Written polices regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family, legal guardian, surrogate, sponsoring agency or representative payee, and the public upon request. A a facility must protect and promote the rights of each resident, including; (4) The right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility I. For Resident #81, kept clean and presentable during and after meals to ensure no food particles on face, mouth, and clothing. II. All residents have the potential to be affected. III. Staff education initiated 6/24/16 and ongoing in promoting and maintaining each resident's dignity with an emphasis on changing of meal napkin during excessive soiling, wiping of face during and after meals, and changing of clothing if soiled due to food particles. Education was conducted by DON/designee. Implement dining monitor during meals to oversight dining experience. Wet wipes will be provided to wipe vs wash resident's faces.	7/08/16

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4 115	Continued From page 4 [redacted]	4 115	Continued from page 4 IV. Audit to be done every day x4 weeks, then 2-3x a week, x2 months. Any issues identified will be recorded and reported monthly to the Quality Assurance Performance Improvement committee meeting. The QAPI committee will evaluate the effectiveness of the plan based on trend identified and implement additional interventions as needed to ensure continued compliance. The DON will oversee this process and will be in compliance by 7/08/16.	

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4 136	11-94.1-30 Resident care The facility shall have written policies and procedures that address all aspects of resident care needs to assist the resident to attain and maintain the highest practicable health and medical status, including but not limited to: (1) Respiratory care including ventilator use; (2) Dialysis; (3) Skin care and prevention of skin breakdown; (4) Nutrition and hydration; (5) Fall prevention; (6) Use of restraints; (7) Communication; and (8) Care that addresses appropriate growth and development when the facility provides care to infants, children, and youth. This Statute is not met as evidenced by: Based on observations, staff interviews and electronic medical record (EMR) reviews, the facility failed to ensure that 1 of 33 residents (R #3), of the Stage 2 survey sample, obtained the highest level of functioning and well-being by not providing the necessary care and services for non-pressure-related skin ulcers. Findings include: [redacted]	4 136	11-94. 1-30 Resident care The facility shall have written policies and procedures that address all aspects of resident care needs to assist the resident to attain and maintain the highest practicable health and medical status, including but not limited to (1) Respiratory care including ventilator use; (2) Dialysis; (3) Skin care and prevention of skin breakdown; (4) Nutrition and hydration (5) Fall prevention (6) Use of restraints; (7) Communication; and (8) Care that addresses appropriate growth and development when the facility provides care to infants, children, and youth. I. For Resident #3, a head to toe assessment was conducted for any new issues. [redacted] assessment was initiated [redacted]. Care plan updated to reflect current medical condition. II. All residents have the potential to be affected. III. Staff education initiated 6/24/16 and ongoing regarding the need to report all changes in skin condition, need to assess all changes and determine cause if able, and implement measures. Education regarding use of EMR to report changes with Stop & Watch tool and for nurses to monitor dashboard. Education and training by DON/designee. Weekly skin assessment to be done for all residents. Weekly wound assessment to be completed for all residents with wound or other significant skin issues. All residents will have a thorough head to toe skin assessment x1 and then per weekly routine.	

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4 136	Continued From page 6 [redacted]	4 136	Continued from page 6 IV. Audits will be done to ensure all resident assessed x1 and then 15 residents weekly x12 weeks with findings verified by Unit Manager or another Licensed Nurse. Any issues identified will be recorded and reported monthly to the Quality Assurance Performance Improvement committee meeting. The QAPI committee will evaluate the effectiveness of the plan based on trend identified and implement additional interventions as needed to ensure continued compliance. The DON will oversee this process and will be in compliance by 7/08/16.	

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4 136	Continued From page 7	4 136		

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4 136	Continued From page 8	4 136		

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4 136	Continued From page 9	4 136		

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4 136	Continued From page 10 [redacted]	4 136		
4 149	11-94.1-39(b) Nursing services (b) Nursing services shall include but are not limited to the following: (1) A comprehensive nursing assessment of each resident and the development and implementation of a plan of care within five days of admission. The nursing plan of care shall be developed in conjunction with the physician's admission physical examination and initial orders. A nursing plan of care shall be integrated with an overall plan of care developed by an interdisciplinary team no later than the twenty-first day after, or simultaneously, with the initial interdisciplinary care plan conference; (2) Written nursing observations and summaries of the resident's status recorded, as appropriate, due to changes in the resident's condition, but no less than quarterly; and (3) Ongoing evaluation and monitoring of	4 149	11-94. 1-39(b) Nursing services (b) Nursing services shall include but are not limited to the following: (1) A comprehensive nursing assessment of each resident and the development and implementation of a plan of care within five days of admission. The nursing plan of care shall be developed in conjunction with the physician's admission physical examination and initial orders. A nursing plan of care shall be integrated with an overall plan of care developed by an interdisciplinary team no later than the twenty-first day after, or simultaneously, with the initial interdisciplinary care plan conference; (2) Written nursing observations and summaries of the resident's status recorded, as appropriate, due to changes in the resident's condition, bu no less than quarterly; and (3) Ongoing evaluation and monitoring of direct care staff to ensure quality resident care is provided	7/08/16

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4 149	Continued From page 11 direct care staff to ensure quality resident care is provided. This Statute is not met as evidenced by: Based on observation, electronic medical record (EMR) reviews and staff interviews, the facility failed to provide an accurate assessment by staff that are qualified to assess the resident with non-pressure-related skin problem for 1 of 33 residents (R #3) on the Stage 2 survey census sample. Findings include: [redacted]	4 149	Continued from page 11 I. Resident #3 was referred to the RNA program [redacted] II. All residents on the Walk and Dine program have the potential to be affected. III. Staff education initiated on 6/24/16 and ongoing regarding the need to provide assistance to maintain the highest practicable ADL function, need to complete assigned care plan tasks and report refusals or change in functional status. Add resident to Walk and Dine care plan for documentation of task completion and monitoring by UM/designee. Education and training done by DON/designee. IV. Audit completion of ambulation programs assigned to CNAs. Audit all assigned residents 2x per week x4 weeks and then a minimum of 10 residents per week x2 months. Any issues identified will be recorded and reported monthly to the Quality Assurance Performance Improvement committee meeting. The QAPI committee will evaluate the effectiveness of the plan based on trend identified and implement additional interventions as needed to ensure continued compliance. The DON will oversee this process and will be in compliance by 7/08/16.	

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4 149	Continued From page 12	4 149		

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4 149	Continued From page 13	4 149		

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4 149	Continued From page 14 [redacted]	4 149		

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4 149	Continued From page 15	4 149		

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4 155	Continued From page 16	4 155		
4 155	11-94.1-40(c) Dietary services (c) A nutritional assessment and care plan shall be recorded in each resident's medical record and integrated into the overall comprehensive assessment and overall plan of care coordinated/integrated with all disciplines. The nutritional assessment and care plan shall be reviewed on a regular basis and adjusted as needed. This Statute is not met as evidenced by: Based on observation, interviews and record review, the facility failed to monitor the therapeutic diet required by one of the 33 residents in the Stage 2 survey sample [redacted] (Resident #133) Findings include: [redacted]	4 155	11-94. 1-40(c) Dietary services (c) A nutritional assessment and care plan shall be recorded in each resident's medical record and integrated into the overall comprehensive assessment and overall plan of care coordinated/integrated with all disciplines. The nutritional assessment and care plan shall be reviewed on a regular basis and adjusted as needed. I. Resident #133 was educated [redacted] by UM regarding current [redacted] orders. MD has been updated regarding resident's choices and behavior regarding diet. Resident and RP signed Risk vs Benefits [redacted] Care plan has been updated. II. All residents with a therapeutic diet have the potential to be affected. III. Staff education initiated on 6/24/16 and ongoing regarding the need to report any variance from ordered diet and emphasize that staff may not provide food/beverages that do not conform to diet without specific direction by DON/designee. Interview residents with therapeutic diet x1 to determine if resident is conforming, needs eduction, or possible liberalization of diet to honor choice. IV. Audit meal set up of 5-10 residents with therapeutic diets per day x1 week and then 5-10 residents per week x3 weeks.	7/08/16

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4 155	Continued From page 17 [redacted]	4 155	Continued from page 17 Any issues identified will be recorded and reported monthly to the Quality Assurance Performance Improvement committee meeting. The QAPI committee will evaluate the effectiveness of the plan based on trend identified and implement additional interventions as needed to ensure continued compliance. The DON will oversee this process and will be in compliance by 7/08/16.	

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4 155	Continued From page 18 [redacted]	4 155		
4 159	11-94.1-41(a) Storage and handling of food (a) All food shall be procured, stored, prepared, distributed, and served under sanitary conditions. (1) Dry or staple food items shall be stored above the floor in a ventilated room not subject to seepage or wastewater backflow, or contamination by condensation, leakages, rodents, or vermin; and (2) Perishable foods shall be stored at the proper temperatures to conserve nutritive value and prevent spoilage. This Statute is not met as evidenced by: Based on observation and interview the facility failed to store food under sanitary conditions. Findings include: During a tour of the kitchen on 6/6/2016, the following were observed; container of diced chicken on top shelf of walk in refrigerator with date marked on it of 5/31/2016. On a shelf near the entrance door to kitchen there was a container of thick and easy powder and container of crackers that both had expiration date of 5/31/2016 marked on them. In the pantry there was opened boxes of of french dressing, mayonaise, salt free seasoning, white miniature marshmallow, dream whip, sweet and low, pepper, sugar, mustard, soy sauce. There was a	4 159	11-94. 1-41(a) Storage and handling of food (a) All food shall be procured, stored, prepared, distributed, and served under sanitary conditions. (1) Dry or staple food items shall be stored above the floor in a ventilated room not subject to seepage or waste water back flow, or contamination by condensation, leakages, rodents, or vermin; and (2) Perishable foods shall be stored at the proper temperatures to conserve nutritive value and prevent spoilage. I. No specific resident was identified. Diced chicken, thick and easy powder and crackers were discarded. II. All residents have the potential to be affected. III. Staff education on proper labeling of items with open date, expiration date and discarding of expired items. III. Staff and Food Service Manager education initiated on 6/13/16 and ongoing regarding proper labeling of items with open date, expiration date and discarding of expired items. IV. Dietary manager/designee will complete 3 audits per week for a minimum of 4 weeks, then monthly x2 months to ensure proper compliance with labeling of products and expired items. Any issues identified will be recorded and reported monthly to the Quality Assurance Performance Improvement committee meeting.	7/08/16

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4 159	Continued From page 19 sign present stating to label boxes when they are opened with with date, expiration date and name. Interview with the FSM #3 on the same day validated these findings were correct.	4 159	Continued from page 19 The QAPI committee will evaluate the effectiveness of the plan based on trend identified and implement additional interventions as needed to ensure continued compliance. The Administrator will oversee this process and will be in compliance by 7/08/16.	
4 175	11-94.1-43(c) Interdisciplinary care process (c) The overall plan of care shall be reviewed periodically by the interdisciplinary team to determine if goals have been met, if any changes are required to the overall plan of care, and as necessitated by changes in the resident's condition. This Statute is not met as evidenced by: Based on resident and staff interviews and EMR reviews, the facility failed to ensure that residents are consulted about care and treatment changes for 1 of 33 residents (R #3)of the Stage 2 survey census sample. Findings include: [redacted]	4 175	11-94. 1-43(c) Interdisciplinary care process (c) The overall plan of care shall be reviewed periodically by the interdisciplinary team to determine if goals have been met, if any changes are required to the overall plan of care and as necessitated by changes in the resident's condition. I. Resident #3 was referred to the RNA program [redacted]. II. All residents on the Walk and Dine program have the potential to be affected. III. Staff education initiated on 6/24/16 and ongoing regarding the need to provide assistance to maintain the highest practicable ADL function, need to complete assigned care plan tasks and report refusals or change in functional status. Add resident to Walk and Dine care plan for documentation of task completion and monitoring by UM/designee. Education and training done by DON/designee. IV. Audit completion of ambulation programs assigned to CNAs. Audit all assigned residents 2x per week x4 weeks and then a minimum of 10 residents per week x2 months. Any issues identified will be recorded and reported monthly to the Quality Assurance Performance Improvement committee meeting. The QAPI committee will evaluate the effectiveness of the plan based on trend identified and implement additional	7/08/16

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4 175	Continued From page 20 [redacted]	4 175	Continued from page 20 interventions as needed to ensure continued compliance. The DON will oversee this process and will be in compliance by 7/08/16.	
4 203	11-94.1-53(a) Infection control	4 203	11-94. 1-53(a) Infection Control	7/08/16

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4 203	Continued From page 21 (a) There shall be appropriate policies and procedures written and implemented for the prevention and control of infectious diseases that shall be in compliance with all applicable laws of the State and rules of the department relating to infectious diseases and infectious waste. This Statute is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to ensure it maintained an infection control program to help prevent the development and transmission of disease and spread of infection. Findings include: [redacted]	4 203	Continued from page 21 There shall be appropriate policies and procedures written and implemented for the prevention and control of infectious diseases that shall be in compliance with all applicable laws of the State and rules of the department relating to infectious diseases and infectious waste. 1. Housekeeping I. Resident #81's curtain was changed. II. All residents have potential to be affected. III. Implemented task sheet and educated housekeeping staff on 7/06/16 and ongoing regarding daily room cleaning assignments and deep cleaning procedures related to precautions and organisms which require specific interventions. Develop tools for documentation on training provided. Implement checklist for cleaning and supervisor's validation. Housekeeping supervisor educated staff on hand washing policy and expectations. IV. Audits of 3-5 resident rooms per week x4 weeks, then 2-3 resident rooms per week x2 months by Housekeeping supervisor/designee. Audits of compliance will consist of daily assignments and validation of completion.	

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4 203	Continued From page 22 [redacted]	4 203	Continued from page 22 Any issues identified will be recorded and reported monthly to the Quality Assurance Performance Improvement committee meeting. The QAPI committee will evaluate the effectiveness of the plan based on trend identified and implement additional interventions as needed to ensure continued compliance. The Administrator will oversee this process and will be in compliance by 7/08/16.	

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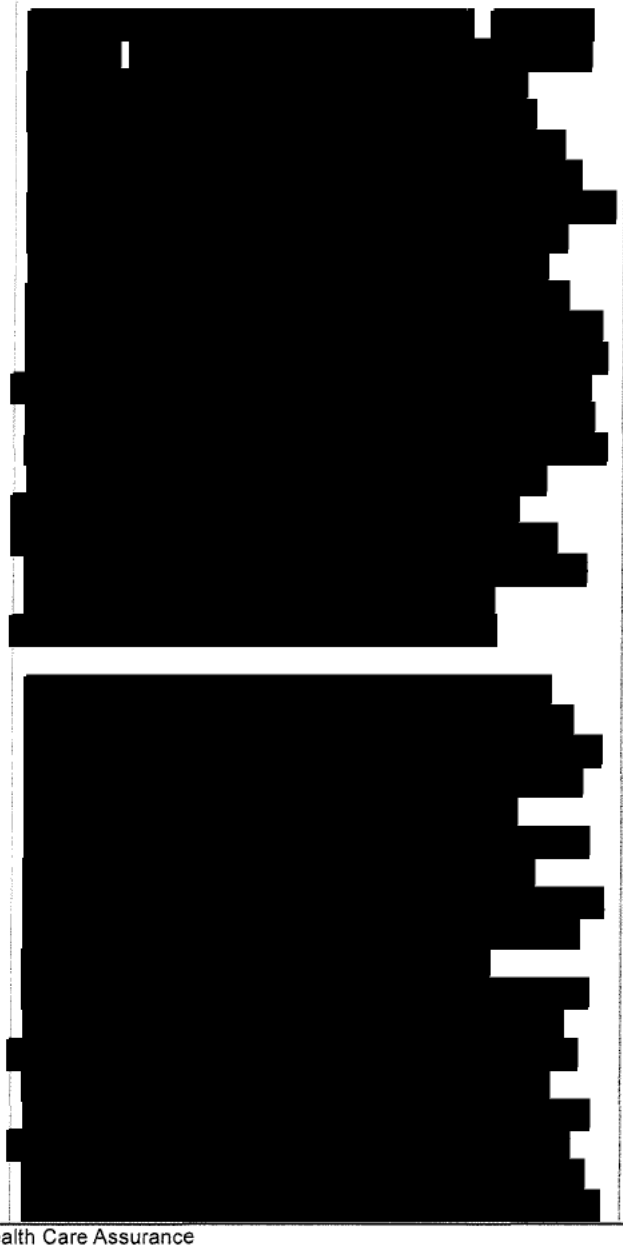
4 203	Continued From page 23	4 203		



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4 203	Continued From page 24 [redacted]	4 203	Continued from page 24	

2. Rehab
I. No residents were identified.

II. All residents who use the rehab unit have potential to be affected.

III. Rehab unit was cleaned and organized. Supplies were cleaned, marked, and organized to clean storage. Education initiated on 6/27/16 and ongoing by Rehab manager/designee regarding need to maintain a clean/organized environment.

IV. Rehab units will be audited weekly x12 weeks to validate items are clean, marked, organized, and not stored with uncleaned items.

Any issues identified will be recorded and reported monthly to the Quality Assurance Performance Improvement committee meeting. The QAPI committee will evaluate the effectiveness of the plan based on trend identified and implement additional interventions as needed to ensure continued compliance. The Administrator will oversee this process and will be in compliance by 7/08/16.

3) Nursing

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4 203	Continued From page 25 [redacted]	4 203	Continued from page 25 I. Resident #56 received [redacted] medications after licensed nurse demonstrated proper hand washing technique prior to medication administration. II. All residents a potential to be affected. III. Staff to be educated on regarding facility hand washing policy. Education initiated on 6/27/16 and ongoing by DON/designee regarding hand washing/sanitizing of hands prior to medication administration. IV. Random audits will be done during medication administration focusing on hand washing/sanitizing of hands to be done on 10 residents per day x1 week, then 10 residents per week x2 months, assuring that all nurses are monitored. Any issues identified will be recorded and reported monthly to the Quality Assurance Performance Improvement committee meeting. The QAPI committee will evaluate the effectiveness of the plan based on trend identified and implement additional interventions as needed to ensure continued	
4 218	11-94.1-55(e) Housekeeping (e) All floors, walls, ceilings, windows, and fixtures shall be kept clean and in good repair. This Statute is not met as evidenced by: Based on observation and interviews the facility failed to provide maintenance services necessary to maintain a comfortable interior. Findings Include: On 6/8/2016 at 2 PM the following observations were seen: in room 206 there was a large crack across the floor in the resident's bedroom approximately 5-6 feet long with black underneath	4 218	11-94. 1-55(e) Housekeeping All floors, walls, ceilings, windows, and fixtures shall be kept clean and in good repair. I. Bathroom for rooms 103, 104, 105, 106, 107, 108, 114, 122, 216, 202, 203, 206, and 211 with wall in poor condition and discoloration marks were serviced by maintenance and repainted. Rooms 107 and 108, bathroom doors with holes were repaired and restored. Resurfacing of bathroom floor in rooms 114, 206, and 211 completed. Bathroom for room 122, 206, 216, 202, and 203 with deteriorating vinyl base edging were repaired with installation of new materials.	7/08/16

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4 218	Continued From page 26 being exposed. Bathroom for room 206 had cracks in the floor of varying sizes with black showing through. Vinyl base edging between the walls and the floor was in poor condition, deteriorating where it was flaking away with parts missing the entire length of the edging. Walls were in poor condition, marks of brown discoloration were present, and condition of wall deteriorating. The bottom half of the walls were covered with some sort of building material that was swollen in some places and warped. Bathroom for rooms 103 and 104, the walls had marks of brown discoloration streaking down them, and were in poor, deteriorating condition where the building material to the bottom half of the wall was warped in places. Bathroom for rooms 105 and 106 had a wall with lots of brown discoloration marks and was in poor condition due to deterioration where the bottom half of the walls were swollen in places and warped in other places. Bathroom for rooms 107 and 108, there were 2 holes in the bottom of the bathroom door, and the wall was in poor, deteriorating condition where the building material on the bottom half of the wall was swollen in places and warped in other places. Bathroom for room 114, there were cracks in the floor exposing black from underneath and the walls were in poor, deteriorating condition where the bottom half of the walls were covered in building material that was warped in places and swollen in other places. . Bathroom for room 122, the vinyl base edging was deteriorating and rotting away where it was flaking away and parts were missing as it had completely rotted through along the length of the edging. The wall was in poor, deteriorating condition where the building material added to the bottom half of the wall was swollen in some places and warped in other places.	4 218	Continued from page 26 Noisy exhaust fans in bathrooms located in rooms 103, 104, 112, 114, 202, and 203 were serviced by facility maintenance to ensure proper functioning and efficiency, vent cleaning, and work maintenance. II. All resident's rooms have the potential to be affected. III. Re-educated staff on 7/06/16 and ongoing to continue use of maintenance clipboards at each nursing station to notify maintenance of items needing repair or replacement. Education conducted by Housekeeping Supervisor/ designee. IV. Audit every room x1, then random audit of 3-5 resident rooms per week x4 weeks, then 2-3 resident rooms per week for 2 months. Any issues identified will be recorded and reported monthly to the Quality Assurance Performance Improvement committee meeting. The QAPI committee will evaluate the effectiveness of the plan based on trend identified and implement additional interventions as needed to ensure continued compliance. The Administrator will oversee this process and will be in compliance by 7/08/16.	

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4 218	Continued From page 27 Bathroom for room 216, the wall, vinyl base edging and floor were in poor, deteriorating condition, where the vinyl was flaking away and parts of it with holes in it. Bathroom for rooms 202 and 203 bathroom, the walls, vinyl base edging and floor were in poor, deteriorating condition where the vinyl edging was flaking away. Bathroom for room 211, a wall was in poor condition where the building material on the bottom half of the wall was swollen in some places and warped in other places and there were cracks in the floor exposing black underneath. Interviews and walk-around with the ADM and maintenance manager validated these findings were correct. Exhaust fans in the following bathrooms are excessively noisy, bathrooms for rooms 103 and 104, 112, 114, 202 and 203.	4 218		
4 246	11-94.1-64(d) Engineering and maintenance (d) The facility shall maintain records that document that inspection of all devices essential to the health and safety of residents and personnel shall be carried out at sufficient intervals to ensure proper operational performance. This Statute is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. Finding includes: During a tour of the facility's rehabilitation unit on	4 246	11-94. 1-64(d) Engineering and maintenance (d) The facility shall maintain records that document that inspection of all devices essential to the health and safety of residents and personnel shall be carried out at sufficient intervals to ensure proper operational performance. I. No resident was affected by this deficient practice. II. Residents who use the Omnicycle have the potential to be affected. III. Facility Director of Rehab educated by regional rehab manager on 6/27/16 and ongoing regarding need to service and maintain equipment per manufacturer's recommendations;	7/08/16

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4 246	Continued From page 28 6/09/2016 at 7:04 AM, there was an omnicycle which the Rehabilitation Services Director (Rehab Director) stated was for residents to use. The last service date on the omnicycle was 9/2014. [redacted] stated the vendor whom they purchased the omnicycle from serviced this equipment. [redacted] confirmed it was important that the omnicycle be serviced timely and that it was not done. On 6/09/2016 at 8:49 AM, the Rehab Director verified the omnicycle equipment, "is good for one year from the marked date" and that its maintenance did expire in September 2015.	4 246	Continued from page 28 that appropriate vendor has inspected and serviced equipment and current sticker is applied. A log to demonstrate service dates for all equipment will be developed and implemented. IV. Log will be reviewed in QAPI monthly. Any issues identified will be recorded and reported monthly to the Quality Assurance Performance Improvement committee meeting. The QAPI committee will evaluate the effectiveness of the plan based on trend identified and implement additional interventions as needed to ensure continued compliance. The Administrator will oversee this process and will be in compliance by 7/08/16.	