**INITIAL COMMENTS**


An annual recertification survey and complaint investigation #29354 were completed at Claiborne County Nursing Home on October 10, 2012. No deficiencies were cited related to complaint investigation #29354 under 42 CFR Part 483, Requirements for Long Term Care Facilities.

**ASSessment**

483.20(g) - (i) 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.

**Resident # 8, identified in this deficient practice will have her Quarterly Minimum Data Set updated to reflect accurately her number of falls, by the MDS Coordinator at the next scheduled update.**

Responsible Person: MDS Coordinator
Completion Date: 11/27/2012

All other Residents utilizing low beds are being reviewed to identify any reported "roll outs" not included as falls on their Quarterly Minimum Data Sets. Any identified deficiencies will have accurate number of "roll outs" classified as falls on their next scheduled Quarterly MDS.

Responsible Person: MDS Coordinator

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**LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE**

[Signature]

**TITLE**

[Title]

**DUE DATE**

10/26/2012

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 required to continued program participation.
F 273 Continued From page 1
Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, review of facility investigation, and interview, the facility failed to accurately document the number of falls on the Quarterly Minimum Data Set for one resident (#8) of eighteen residents reviewed.

The findings included:
Resident #8 was admitted to the facility on May 11, 2011, and readmitted to the facility on May 29, 2012, with diagnoses including Gastrostomy, Failure to thrive, Congestive Heart Failure, Hypoxemia, Rheumatoid Arthritis, Vascular Dementia, and Psychosis.


Review of a Quarterly Minimum Data Set (MDS) dated September 4, 2012, revealed documentation the resident had one fall with injury since prior MDS Initial Assessment dated June 11, 2012.

Interview on October 9, 2012, at 3:00 p.m., in the Dining Room, with the MDS Coordinator, confirmed the Quarterly MDS did not accurately document the number of falls the resident had

The MDS and PPS coordinators have been educated to include "roll out of low beds" as a fall, using the state definition of a fall being any unplanned change of plane.

They were also instructed to accurately report these on Quarterly MDS profiles.

Responsible Person: Director of Nursing

All event reports will be reviewed by Director of Nurses or his designee and the MDS Coordinator to ensure that "roll outs of low beds" are reported on MDS as falls.

# of "low bed roll outs" reported per Resident + # of falls reported per Resident = the total # of falls documented on Quarterly MDS updates. This data will be collected and aggregated by the MDS Coordinator and reported to the Director of Nursing and Administrator on a monthly basis.

Responsible Person: MDS Coordinator
F. 278: Continued From page 2

Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.

This REQUIREMENT is not met as evidenced by:

Based on observation and interview, the facility failed to label and date tube feeding solution for one resident (#5) of eighteen residents reviewed.

The findings included:

Resident #5 was admitted to the facility on July 15, 2009, and readmitted to the facility on June 6, 2012, with diagnoses including Chronic Kidney Disease, Uncontrolled Diabetes, Dementia, Psychosis, Peripheral Vascular Disease, Gastrostomy, and Stage 4 Pressure Ucer.

Observation of the resident on October 8, 2012, at 1:00 p.m., 3:45 p.m., and 4:30 p.m., revealed the resident receiving continuous tube feeding solution at 86 ml (milliliters) per hour via pump and gastrostomy tube (a tube surgically placed into the stomach through the abdominal wall). Continued observation revealed the solution was contained in a 1200 ml opaque plastic container with the manufacturer's label.

F. 322

F. 322

Resident #5 identified in this deficient practice immediately had the date and time added to his enteral feeding container, by the LPN providing resident care.

Responsible Person: Director of Nursing

The licensed staff member identified as involved in the deficient practice was reeducated by the Director of Nurses on the importance of compliance with facility policies and procedures regarding labeling and dating of enteral feedings.

100% of Residents receiving enteral feedings have been reviewed to ensure feeding container is correctly labeled and dated.

Responsible Person: Director of Nursing

100% of the licensed nursing staff will be educated on the importance of compliance with facility policy and procedure with emphasis on labeling and dating enteral feeding containers. Attendance of education sessions will be verified by
**F 322. Continued From page 3**

Affixed and no date or time of administration was noted on the container or the line from the container to the resident.

Interview with LPN #2 on October 8, 2012, at 4:35 p.m. at the 200 hall nursing station, revealed the administration of the solution began on October 7, 2012, at 10:00 p.m., and confirmed the facility had failed to ensure the time and date of administration was on the label.

**F 323**

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 medical record review, observation, review of facility investigation, and interview, the facility failed to ensure proper use of safety devices for two residents (#8, #13), failed to properly ensure the safety of one resident (#8) during transfer using a Hoyer lift, failed to document and ensure implementation of new interventions to prevent future falls for one resident (#8), and failed to transfer one resident (#12) per care plan, of eighteen residents reviewed.

The findings included:

F 322 continued

Participants signature on the “sign-in” sheet.

Responsible Person: Director of Nurses

Compliance rate will be determined by the # of Residents enteral feeding containers that are labeled and dated / total # of residents with enteral feedings = rate of compliance.

Expected compliance is expected to be 100%. Daily walk through rounds by Charge Nurses will be used to collect compliance data.

The Charge Nurses will submit the data to the Director of Nurses. The Director of Nurses will aggregate the data and report compliance rate to the Administrator and Medical Director for three months of sustained compliance. This data will then be reported to the Quality Management Committee.

Responsible Person: Director of Nurses
F 323

Continued From page 4

Resident #8 was admitted to the facility on May 11, 2011, and readmitted to the facility on May 29, 2012, with diagnoses including Gastrostomy, Failure to Thrive, Congestive Heart Failure, Hypoxemia, Rheumatoid Arthritis, Vascular Dementia, and Psychosis.

Review of the Quarterly Minimum Data Set (MDS) dated September 12, 2012, revealed the resident had severely impaired cognition and required extensive assistance with activities of daily living (ADLs).

Observation of the resident’s room on October 8, 2012, at 2:15 p.m., revealed alarms and motion sensors to each side of the resident’s bed and fall mats to both sides of the resident’s bed.

Observation of the resident on October 8, 2012, at 2:30 p.m., outside the second floor nurse’s station, revealed the resident sitting in a rocking wheelchair with sensor alarms to each side of the wheelchair and a wanderguard bracelet attached to the resident’s right ankle.

Review of facility investigations dated October 1, 2011, October 29, 2011, November 2, 2011, November 14, 2011, December 29, 2011, and March 3, 2011, revealed the resident had falls without injury. Continued review revealed interventions of "...continue low bed alarm...respond to alarms quickly...Make sure bed alarm pad laying horizontal...continue low bed and alarms...continue low bed with fall mats bilaterally...continue to keep fall mats at bedside and respond to alarms, continue low bed."

Review of a facility investigation dated April 5,
F 323 Continued From page 5

2012, revealed the resident while seated in a wheelchair in front of the second floor nurse's station, flipped the wheelchair over without injury. Continued review of the facility investigation revealed alarm on wheelchair "...was not turn on..."

Review of facility investigations dated June 2, 2012, June 12, 2012, June 16, 2012, July 4, 2012, July 16, 2012, and July 20, 2012, revealed the resident had falls without injury. Review of the facility investigations revealed interventions of "...alarm on resident at all times, instructed daughter...Place bolsters on sides of bed...monitor frequently, maintain alarms, PT (physical therapy) screen...continue use of low beds and alarms...monitor resident frequently when restless behavior...continue low bed and respond to alarms as quick as possible..."

Continued review revealed no new interventions implemented to prevent further falls on July 4, 2012, or July 20, 2012.

Review of a facility investigation dated July 28, 2012, revealed the resident had a fall on the residents' room resulting in no injury to the resident. Continued review of the facility investigation revealed safety alarms were not sounding, mobile alarms did not detach from the resident, and "...motion sensor turned off...AC adaptor not plugged into alarm..."

Review of facility investigations dated August 14, 2012 and August 31, 2012, revealed the resident had falls without injury. Continued review revealed no new interventions were implemented to prevent further falls after the August 14, 2012, fall. Continued review revealed interventions of

F 323 Resident and employees. No further occurrences involved this employee.

Responsible Person: Director of Nurses

Employee that was involved in the deficient practice involving Resident # 13 on 04/17/2012 was counseled about the importance of making sure the Resident alarm is applied and operating properly. No further occurrences involved this employee.

Responsible Person: Director of Nurses

Employee that was involved in the deficient practice with Resident # 12 on 06/11/2012 was counseled about the importance of following the Residents care plan for the safety of Resident and employee. No further occurrences involved this employee.

Responsible Person: Director of Nurses
...monitor frequently when up in w/c (wheelchair) and reposition resident back in w/c when needed; OT (occupational therapy) to screen...

Review of a facility investigation dated September 19, 2012, revealed the resident was dropped without injury during a transfer to bed by one staff person using a Hoye lift (device used to transfer residents who cannot safely transfer themselves). Further review of the facility investigation revealed, "...should have x2 (times two) staff with transfers with lift..." Medical record review of the Care Plan updated on September 20, 2012, revealed, "...Only 1 CNA (Certified Nurse Assistant) was present at time of fall. 2 CNA (s) are supposed to be present during TR (transfer) with lift..."

Interview on October 9, 2012, at 2:46 p.m., with the Director of Nursing (DON), in the DON's office, confirmed the safety devices in place at the time of the resident's falls on April 5, 2012, and July 26, 2012, were not functioning properly.

Continued interview with the DON confirmed two staff members were required to be present while transferring the resident with a Hoye lift and the resident's care plan was not followed resulting in a fall on September 19, 2012.

Further interview with the DON confirmed no new interventions were implemented after falls on November 14, 2011, December 29, 2011, and March 31, 2012.

Continued interview confirmed "were not aware of other interventions to be attempted" on additional falls which occurred on July 4, 2012.

With physician order, we have removed Resident #8 bilateral ½ length bed rails, as a new intervention to help decrease the number of repeated "roll outs" of low beds. All other furniture has been moved from area of "roll outs" to prevent injury.

Responsible Person: Director of Nurses

100% of the Nursing Home direct patient care staff will be educated on the importance of compliance with facility policies and procedures and individual Resident’s care plan, for the safety of the Resident and the staff. Emphasis to be made on correct application of safety monitors and validation of their functionality. Emphasis will also be made on the necessity and importance of compliance with individual Resident’s care plans.

Attendance of education session will be verified by participants signature on the "sign-in" sheet.

Responsible Person: Director of Nurses
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<thead>
<tr>
<th>F 323</th>
<th>Continued From page 7</th>
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<tbody>
<tr>
<td></td>
<td>Resident #13 was admitted to the facility on September 11, 2010, with diagnoses including Carotid Artery Stenosis, Acute Myocardial Infarction, and Parkinson's Disease.</td>
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<td>Observation of the resident in the resident's room, on October 10, 2012, at 9:46 a.m., revealed the resident lying in bed with a full padded side rail up on the right side of the bed. Continued observation revealed an alarm hanging from the side rail of the bed.</td>
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<td>Review of a facility investigation dated April 17, 2012, revealed &quot;...found R (resident) on BR (bedroom) S0B (side of bed)...alarm attached to R and bed still...&quot; Further review revealed, &quot;...make sure mobile alarm is attached to bedrail where will not slide with resident...&quot;</td>
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<td>Interview on October 10, 2012, at 10:20 a.m., with the DON. In the DON's office, confirmed the facility had failed to ensure the safety alarms were applied correctly to alert staff of unassisted transfers.</td>
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<td>Resident #12 was admitted to the facility on January 12, 2012, with diagnoses of Renal Dialysis, Chronic Kidney Disease, Malaise and Fatigue, and Diabetes Mellitus Type II.</td>
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<td>Medical record review of the Care Plan revealed the resident fell on May 2, 2012, with no injury, and the Care Plan had been updated to include interventions to prevent falls including &quot;...assist of two for transfers...&quot;</td>
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Continued from page 8

Continued medical record review of the Care Plan revealed the resident fell again on June 11, 2012, and was updated to include "...Resident was lowered to floor during transfer with assist x1. Resident needs assist x2 for safe transfers."

Review of facility investigation dated June 11, 2012, revealed "...transfer with assist of one with fall..care plan called for assist of two...educate CNA (Certified Nursing Assistant) on following care plan for assist of two on transfers...PT (Physical Therapy) to evaluate."

Interview with the Assistant Director of Nursing (ADON), in the DON's office, on October 10, 2012, at 10:20 a.m., confirmed the resident's fall on June 11, 2012, was the result of the CNA not following the care plan.

F 441, 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS

The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection.

(3) Infection Control Program
The facility must establish an infection control program under which it -
(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

Bullet #2 of POC For F323

100% of residents with alarm devices and side rails were checked by Charge nurses for functioning alarms and proper placement 10/11/2012. 100% of devices checked were found to be properly attached and with functioning alarm. Only the one bedrail of Resident #8 required intervention. Daily assessments made by licensed personnel.

Responsible Person: Director of Nurses
Continued From page 8

Continued medical record review of the Care Plan revealed the resident fell again on June 11, 2012, and was updated to include "...Resident was lowered to floor during transfer with assist x1. Resident needs assist x2 for safe transfers."

Review of a facility investigation dated June 11, 2012, revealed "...transfer with assist of one with fall...care plan called for assist of two...educate CNA (Certified Nursing Assistant) on following care plan for assist of two on transfers...PT (Physical Therapy) to evaluate..."

Interview with the Assistant Director of Nursing (ADON), in the DON's office, on October 10, 2012, at 10:20 a.m., confirmed the resident's fall on June 11, 2012, was the result of the CNA not following the care plan.

F 441
480.65 INFECTION CONTROL, PREVENT SPREAD, LINENS

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program
The facility must establish an Infection Control Program under which it -
(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

F441
Immediately after the nurse became aware of the identified deficient practice involving Resident #3, the undated nebulizer mask was removed and replaced with a new mask with date placed on the mask. 100% of Residents with orders for nebulizer masks/treatments were checked to make sure masks were clean and dated.

Responsible Person: Director of Nurses
F 441 Continued From page 9

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personal must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on observation, review of facility policy, and interview, the facility failed to provide a sanitary, labeled, nebulizer facemask for one resident (#8), of eighteen residents reviewed.

The findings included:

Resident #8 was admitted to the facility on July 31, 2008, with diagnoses of Gastroesophageal reflux disease, paranoid schizophrenia, bipolar disorder, psychosis, and anxiety. The resident was admitted with a nebulizer mask and was instructed to use it daily.

Observation of the resident during the initial tour on October 8, 2012, at 10:50 a.m., revealed the nebulizer mask was not being used as instructed. The resident was observed to be using a nebulizer mask that was not labeled or marked as such, and the mask was not properly stored or handled.

100% of the licensed nursing staff will be educated on the importance of compliance with facility policies and procedures, focusing on scheduled changing and dating nebulizer masks on a weekly and PRN basis. Attendance of education session will be verified by participant signature on the “sign-in” sheet. Responsible Person: Director of Nurses

Compliance rate will be determined by the # of Resident’s that have nebulizer masks that are dated and clean / Total # of Residents with orders for nebulizer masks or treatments = rate of compliance. Expected compliance is to be 100%. Daily walk through rounds by the charge nurses will be used to gather compliance data. The charge nurses will provide the data to the Director of Nurses who will aggregate and trend it. The Director of Nurses will then report the compliance data to the Administrator and Medical
<table>
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<th>F 441</th>
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<tr>
<td>Respiratory nebulizer face mask in a clear plastic bag was undated, without the resident's name, and had a buildup of a yellow substance inside the mask.</td>
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<td>Review of facility policy, Oxygen Therapy, revised October 2008, revealed &quot;...Change handheld nebulizer setups weekly. Keep setup in plastic bag when not in use, labeled with resident's name and date...&quot;</td>
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<tr>
<td>Interview with Licensed Practical Nurse (LPN) #1 in the residents' room on October 6, 2012, at 10:53 a.m., confirmed the nebulizer mask had a buildup of a yellow colored substance and did not have a date or name written on it. Continued interview confirmed LPN #1 could not provide documentation of when the nebulizer mask had been changed.</td>
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<th>F 514</th>
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<tbody>
<tr>
<td>RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</td>
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<tr>
<td>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</td>
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<td>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</td>
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<td>This REQUIREMENT is not met as evidenced</td>
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| F 441 cont. |
| Director monthly for at least three months or until sustained compliance is achieved for three consecutive months. The Director of Nurses will report this data to the Quality management Committee bimonthly at scheduled meetings. |

| F 514 |
| Immediately after staff became aware of the deficient practice identified involving Resident #13, the physician recapitulation orders were placed on the chart. |
| Responsible Person: Director of Nurses |
| Completion Date: 10/10/2012 |
| 100% of Resident medical records were reviewed to make sure that physician recapitulation orders were on chart and current. |
| Responsible Person: Director of Nurses |
| Completion Date: 10/12/2012 |
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**
CLAIBORNE COUNTY NURSING HOME

**STREET ADDRESS, CITY, STATE, ZIP CODE**
1850 OLD KNOXVILLE ROAD
TAZEWELL, TN 37879

**DATE SURVEY COMPLETED**
10/10/2012

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<table>
<thead>
<tr>
<th>ID PREFIX</th>
<th>TAO</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX</th>
<th>TAO</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>DCS COMPLETION DATE</th>
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<tr>
<td>F 514</td>
<td></td>
<td>Continued From Page 11 by: Based on medical record review and interview, the facility failed to maintain a current and readily accessible clinical record for one resident (613) of eighteen residents reviewed. The findings included: Resident #613 was admitted to the facility on September 11, 2010, with diagnoses including Cerebrovascular Accident, Altered Mental Status, Old Myocardial Infarction and Parkinson's Disease. Medical record review of Physician Recapitulation Orders revealed the Physician Recapitulation Orders were last signed and dated by the Physician on July 27, 2012, and &quot;...No order may stand for more than 60 days...&quot; Continued medical record review revealed no additional Physician Recapitulation orders in the medical record after July 27, 2012. Interview on October 10, 2012, at 8:10 a.m., with the Director of Nursing (DON) in the DON's office, confirmed Physician Recapitulation Orders were not current and not in the resident's chart.</td>
<td>F 514</td>
<td></td>
<td>100% of physician recapitulation orders will now be completed every 30 days, with Resident charts divided relative to room/floor assignment. This division will promote continuity and eliminate the possibility of oversight. 100% of licensed nursing staff will be educated on this revised process and the importance of maintaining this rotating schedule. Attendance of this education session will be validated by employee signatures on the &quot;sign-in&quot; sheet. Responsible Person: Director of Nurses 100% chart review will be conducted by Director of Nurses designee(s) monthly by the date recapitulation is scheduled to be completed on each floor. # of charts with completed recapitulation / Total # of Resident charts due recapitulation = % compliance. Expected compliance rate is 100%. The Director of Nursing will aggregate this data and...</td>
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<td>F514</td>
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<td>Based on medical record review and interview, the facility failed to maintain a current and readily accessible clinical record for one resident (#13) of eighteen residents reviewed.</td>
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The findings included:

Resident #13 was admitted to the facility on September 11, 2010, with diagnoses including Cerebrovascular Accident, Altered Mental Status, Old Myocardial Infarction and Parkinson's Disease.

Medical record review of Physician Recapitulation Orders revealed the Physician Recapitulation Orders were last signed and dated by the Physician on July 27, 2012, and "...No order may stand for more than 60 days...". Continued medical record review revealed no additional Physician Recapitulation orders in the medical record after July 27, 2012.

Interview on October 10, 2012, at 8:10 a.m., with the Director of Nursing (DON) in the DON's office, confirmed Physician Recapitulation Orders were not current and not in the resident's chart.

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<td>report compliance rate monthly to the Administrator and bimonthly at scheduled Quality Management Committee meetings. This will be done for at least 3 months or longer until sustained acceptable compliance is achieved and maintained.</td>
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