

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435122</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/14/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>ST WILLIAM'S CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>100 SOUTH 9TH STREET MILBANK, SD 57252</b>	
(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  Surveyor: 33488 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 05/12/15 through 05/14/15. St William's Care Center was found not in compliance with the following requirement(s): F176, F221, and F281.	F 000		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE  An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.  This REQUIREMENT is not met as evidenced by: Surveyor: 34030 Based on observation, interview, record review, and policy review, the provider failed to assess and obtain a physician's order to self-administer a medication for one of one random resident (16) observed during medication administration. Findings include:  1. Observation on 5/12/15 at 11:05 a.m. with licensed practical nurse (LPN) A during medication administration of a nebulizer (a device that turns liquid medication into a mist for inhaling into the lungs) treatment for resident 16 revealed she had to: *Placed the medication into the nebulizer chamber. *Placed the inhalation mask on the resident's face and started the machine. *Left the resident's room to pass other	F 176	<p><i>Amendments noted with an asterisk per 6/17/15 telephone to facility DON. NPN/KDDOH/ME</i></p> <p><b>F 176</b> <b>The Medication Administration Policy</b> was updated to include the following statement: When an order is received for a nebulized medication, a <b>Self-Medication Assessment</b> will be completed to assess the resident's ability to safely follow the administration instructions for the medication and a physician's order received allowing self-administration, if the resident is capable of having a nebulizer running without a nurse/med aide present. <i>*by a licensed nurse NPN/KDDOH/ME</i> A Self-Medication Assessment was completed on resident 16 on 6/2/15 and it was determined that resident 16 is not capable of self-administration of her nebulized medication.</p>	6/3/15

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

*S. Mary Walker*

TITLE

*Administrator*

(X6) DATE

*6/5/2015*

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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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 176	<p>Continued From page 1 medications.</p> <p>*Returned to the resident's room when the treatment was done to clean the nebulizer mask and chamber.</p> <p>Interview with LPNA at that time revealed: *She had not stayed with the resident during the nebulizer administration. **"This is how we usually do it. We have too many (treatments) that need to be done."</p> <p>Review of resident 16's medical records revealed: *A diagnosis of dementia (a decrease in the ability to think and remember). *The nebulizer treatments had been done since 2/26/15. *There had not been a physician's order for medication self-administration. *There was no assessment done to determine if the resident was capable of being left alone during the treatment.</p> <p>Interview on 5/13/15 at 3:30 p.m. with the director of nursing revealed she was unaware staff were not staying with the residents during administration of the nebulizer treatments.</p> <p>Review of the provider's undated policy on Administration of Nebulizer Therapy revealed how to perform the treatment. Nothing was provided that mentioned assessment of the resident's capability to self-administer a medication nor a policy on physician's orders to do so.</p> <p>Review of Patricia A. Potter et al., Fundamentals of Nursing, 8th Edition, Elsevier, St. Louis, Mo., 2013, page 565, revealed: "In all settings, nurses are responsible for evaluating the effects of medications on the patient's ongoing health</p>	F 176	<p>Twenty other residents were noted to have orders for nebulized medications. Six have scheduled nebulized medications and twelve have PRN orders. 8 out the 20 residents were assessed as being capable of self-administration of their nebulized medication.</p> <p>Upon review by Nursing staff and resident's physician it was deemed clinically appropriate to discontinue nebulized medication administration for 7 of the residents with PRN orders. Orders were received.</p> <p>The EMR's (Electronic Medical Record) for the 6 residents with scheduled nebulized medications were reviewed for self-administration and physician's orders. Assessments were updated and orders requested/received for self-administration.</p>	
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F 176	<p>Continued From page 1 medications. *Returned to the resident's room when the treatment was done to clean the nebulizer mask and chamber.</p> <p>Interview with LPN A at that time revealed: *She had not stayed with the resident during the nebulizer administration. **"This is how we usually do it. We have too many (treatments) that need to be done."</p> <p>Review of resident 16's medical records revealed: *A diagnosis of dementia (a decrease in the ability to think and remember). *The nebulizer treatments had been done since 2/26/15. *There had not been a physician's order for medication self-administration. *There was no assessment done to determine if the resident was capable of being left alone during the treatment.</p> <p>Interview on 5/13/15 at 3:30 p.m. with the director of nursing revealed she was unaware staff were not staying with the residents during administration of the nebulizer treatments.</p> <p>Review of the provider's undated policy on Administration of Nebulizer Therapy revealed how to perform the treatment. Nothing was provided that mentioned assessment of the resident's capability to self-administer a medication nor a policy on physician's orders to do so.</p> <p>Review of Patricia A. Potter et al., Fundamentals of Nursing, 8th Edition, Elsevier, St. Louis, Mo., 2013, page 565, revealed: "In all settings, nurses are responsible for evaluating the effects of medications on the patient's ongoing health</p>	F 176	<p>The Director of Nursing (DON) or her designee will review new orders/order changes weekly x 6 weeks and monthly x 4 months to ensure self-medication assessments are completed and physician orders received when appropriate.</p> <p><i>*by a licensed nurse NPN/SDD/HMF</i></p> <p><i>* Results will be reported by the DON or designee to the QA#A committee at the monthly leadership meeting every month times 4 months. NPN/SDD/HMF</i></p>	
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F 176	Continued From page 2 status, teaching them about their medications, and side effects, ensuring adherence to the medication regimen, and evaluating the patient's and family caregiver's ability to self-administer medications."	F 176	F 221	6/2/15
F 221 SS=D	<p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 16385</p> <p>Surveyor: 35625 Based on interview, record review, and policy review, the provider failed to ensure one of one sampled resident (6) had a physician's order and completed assessments for the use of a Merry Walker (a walker with four sides and a seat). Findings include:</p> <p>1. Review of resident 6's medical record revealed an absence of: *A physician's order for the use of the Merry Walker. *Regular assessments by staff evaluating the use of the restraint.</p> <p>Random observations from 5/12/15 through 5/14/15 revealed resident 6 had used the Merry Walker to ambulate in the hallways.</p> <p>Interview on 5/12/15 at 1:45 p.m. with the director</p>	F 221	<p>A restraint assessment was completed on resident #6 on 6/2/15 and a physician's order received for resident's use of a Merry Walker. Physician had previously observed him using it routinely and included a comment in his progress note about the resident was using a Merry Walker.</p> <p>A restraint assessment in the EMR (Electronic Medical Record) will be completed on a quarterly basis <i>*DR WITH A SIGNIFICANT change. NPN/SDDH/MF</i> Use of the restraint was reviewed with the resident's family at a scheduled Care Conference on 5/13/15. Interdisciplinary Team (IDT) is in agreement that the Merry Walker was appropriate for the resident. This resident's family has been pleased with him having increased opportunity for ambulating independently.</p>	

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F 176	Continued From page 2 status, teaching them about their medications, and side effects, ensuring adherence to the medication regimen, and evaluating the patient's and family caregiver's ability to self-administer medications."	<del>F 176</del>	He is able to locate and use the seat appropriately. He can open the bar that closes across the front of the walker, but cognitively may not do so if asked to open it; therefore, this appliance is being considered a restraint.	
F 221 SS=D	<p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 16385</p> <p>Surveyor: 35625 Based on interview, record review, and policy review, the provider failed to ensure one of one sampled resident (6) had a physician's order and completed assessments for the use of a Merry Walker (a walker with four sides and a seat). Findings include:</p> <p>1. Review of resident 6's medical record revealed an absence of: *A physician's order for the use of the Merry Walker. *Regular assessments by staff evaluating the use of the restraint.</p> <p>Random observations from 5/12/15 through 5/14/15 revealed resident 6 had used the Merry Walker to ambulate in the hallways.</p> <p>Interview on 5/12/15 at 1:45 p.m. with the director</p>	F 221	<p>Continued use will be reviewed with the resident's family and IDT on a Quarterly basis during future scheduled Care Conferences.</p> <p><i>*use is also reviewed by the IDT weekly at the scheduled medicate meeting to monitor for any significant change.</i> NPN/SSDOHMF</p> <p><i>*The DON or the restorative nurse will monitor that the assessments are being completed quarterly and will report x 2 to the QAA committee at the monthly leadership meeting on the resident's ability to continue to use the merry walker.</i> NPN/SSDOHMF</p>	

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F 221	Continued From page 3 of nursing (DON) regarding resident 6 revealed: *The resident was using the Merry Walker to ambulate in the facility. *She was unsure if resident 6 could consistently open the bar to exit the device. *She acknowledged there was no physician's order in the medical record. *No assessments had been completed by the nursing staff for the use of the walker. *It was her expectation that a physician's order be obtained and assessments completed for the use of a restraint.  Review of the provider's undated Protective Devices and Restraint Use policy revealed: *A physician's order would be obtained. *Comprehensive assessments would be completed to evaluate the necessity of the restraint. *Alternatives to the restraint would be documented in the medical record.	F 221			
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Surveyor: 16385  Surveyor: 35625 Based on interview, record review, and policy review, the provider failed to obtain indications for use on numerous physician ordered medications for 5 of 13 sampled residents (2, 3, 5, 7, and 12). Findings include:	F 281	<b>F281</b> The physician's orders for residents 2,3,5,7, and 12 were reviewed. Indications for use were needed for medications on all 5 residents.	7/3/15	

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F 281	Continued From page 4  1. Review of resident 2's medical record revealed: *The indication for use with citalopram (a medication to improve mood) was listed as "mood." -No medical diagnosis was listed. *There was no indication for use with losartan (a medication to lower blood pressure).  Surveyor: 35121 2. Review of resident 3's medical record revealed there was no indication for use on the physician's orders for the following medications: *Xanax (for anxiety). *Losartan (for blood pressure). *Albuterol (for shortness of breath). *Vitamin D3. *Spiriva (for shortness of breath). *Tylenol (for pain). *Dulcolax suppository (for constipation). *Milk of Magnesia (for constipation).  3. Review of resident 7's medical record revealed there was no indication for use on the physician's orders for the following medications: *Lasix (for fluid retention). *Aspirin EC. *Vitamin D3. *Kaopectate (for diarrhea).  4. Review of resident 12's medical record revealed there was no indication for use on the following medications: *Loperamide (for diarrhea). *Qvar (for shortness of breath). *Albuterol.	F 281	A list of medications needing indications for use/diagnosis was taken to the resident's physician for review and appropriate diagnoses were added to the resident's Electronic Medical Record (EMR).  The EMR of the remaining residents will be reviewed and physicians will be contacted to provide appropriate diagnosis for the resident's medications where necessary.  The Director of Nursing (DON) and the Consultant Pharmacist will monitor each resident's EMR monthly for 6 months to ensure there is a diagnosis for each medication listed.		

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F 281	Continued From page 5 Interview on 5/13/15 at 2:45 p.m. with the DON revealed she agreed there was no indication for use on the physician's orders for the above medications for those residents.  Surveyor: 33488 5. Review of resident 5's medical record revealed she had physician's orders for thirteen medications that had no indication for use for the following: *Milk of Magnesia (laxative) 30 milliliters (ml) by mouth daily as needed. *Baby Aspirin: by mouth daily. *Calcium Citrate + Vitamin D: two tablets by mouth twice a day. *Nexium (acid reliever): one by mouth daily. *Warfarin Sodium (blood thinner): -Take 4 milligrams (mg) by mouth on Monday, Tuesday, Wednesday, Friday, and Saturday during supper. -Take 0.5 mg by mouth on Monday, Tuesday, Wednesday, Friday, and Saturday during supper. -Take 5 mg by mouth on Thursday and Sundays during supper. *Sertraline (antidepressant): 100 mg by mouth daily at breakfast. . *Tylenol (pain reliever or fever reducer): -Take two tablets by mouth daily as needed. -Take two tablets by mouth three times per day. *Potassium chloride (supplement): 20 milli-equivilants (meq). Take two capsules of 10 meq by mouth twice a day at breakfast and supper. *Gabapentin (used commonly for nerve pain): 600 mg by mouth three times per day. *Hydrocodone-Acetaminophen (narcotic pain reliever) 5/325 mg. Take one tablet by mouth every four hours as needed. .	F 281	Medications for all new admissions will be reviewed by the DON and by the Consultant Pharmacist ongoing to ensure that there is a diagnosis for each medication. The Physician/Physician extender will be contacted as necessary to clarify orders.  The results of the reviews will be reported to the QA &A committee for 6 months* by the Director of Nursing or designee. <i>NPN/SDOH/ME</i>	

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F 281	Continued From page 6  6. Interview on 5/12/15 at 4:25 p.m. with the director of nursing regarding indications for use not included in the physicians' orders for the residents listed above revealed: * "We don't always get one (an indication for use). I understand we do need them." * It was her expectation nursing staff would know why they were to be giving the medication to the resident. * She believed if they had one (an indication for use), it would have been inputted into the electronic medical record in the physician's orders when it was received.  The provider had no policy related to medication indications for use as it referred to physician's orders.  Review of the Lippincot's Nursing Center, 8 Rules for Medication Administration, dated 5/27/11, <a href="http://www.nursingcenter.com/blog/post/2011/05/27/8-rights-of-medication-administration.aspx">http://www.nursingcenter.com/blog/post/2011/05/27/8-rights-of-medication-administration.aspx</a> , accessed on 5/18/15, revealed rule number 7: "Confirm the rationale for the ordered medication. What is the patient's history? Why is he/she taking this medication?"	F 281			

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ORIGINAL

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K 000	INITIAL COMMENTS  Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 5/12/15. St William's Care Center was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.  The building will meet the requirements of the 2000 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 5/12/15 upon correction of the deficiencies identified below.  Please mark an "F" in the completion date column for the deficiency identified as meeting the FSES to indicate the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 033 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD  Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1  This STANDARD is not met as evidenced by: Surveyor: 14180 Based on observation and record review, the provider failed to maintain a protected path of egress from the basement to the exterior of the	K 033		"F"

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

TITLE

(X6) DATE

*S. Mary Walker*

Administrator

5/5/2015

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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OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER  <b>ST WILLIAM'S CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>100 SOUTH 9TH STREET MILBANK, SD 57252</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 033	<p>Continued From page 1 building. One basement stairway discharged onto the main level and was not provided with a one hour fire resistive enclosure to the exterior of the building. Findings include:</p> <p>1. Observation at 11:30 a.m. on 5/12/15 revealed a basement stairway that discharged onto the main level corridor system of Hummingbird Lane. That condition did not provide a continuous protected exit passage to the exterior of the building. Review of the previous life safety code survey confirmed that condition had existed since the original construction.</p> <p>The building meets the FSES. Please mark an "F" in the completion date column to indicate the provider's intent to correct deficiencies identified in K000.</p>	K 033			

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10649</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/14/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ST WILLIAM'S CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>100 S 9TH ST MILBANK, SD 57252</b>
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S 000	Initial Comments  Surveyor: 33488 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 5/12/15 through 5/14/15. St William's Care Center was found not in compliance with the following requirement(s): S0236.	S 000	<i>Addendums noted with an asterisk per 6/17/15 telephone to facility DON. NPN/SDDOH/MF</i>	
S 236	44:04:04:08.01 TUBERCULIN SCREENING REQUIREMENTS  Tuberculin screening requirements for healthcare workers or residents are as follows:  (1) Each new healthcare worker or resident shall receive the two-step method of Mantoux skin test to establish a baseline within 14 days of employment or admission to a facility. Any two documented Mantoux skin tests completed within a 12 month period prior to the date of admission or employment shall be considered a two-step. Skin testing is not necessary if documentation is provided of a previous positive reaction of ten mm induration or greater. Any new healthcare worker or resident who has a newly recognized positive reaction to the skin test shall have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease;  This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 34030 Based on record review, interview, and policy review, the provider failed to administer tuberculosis (TB) screening within two weeks of	S 236	S236 Employee B received her 1 <sup>st</sup> TB test on 5/12/15 and her 2 <sup>nd</sup> TB test on 05/20/15. Her hire date was 4/3/15.  The TB control plan policy was updated to include that all new employees will receive a 2 step baseline screening within the first two weeks of hire.	6/3/15

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

*May Walker*

TITLE

*Administrative*

(X6) DATE

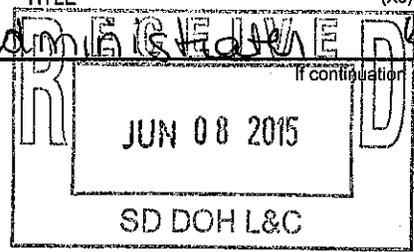
*6/5/2015*

STATE FORM

6899

RXDF11

If continuation sheet 1 of 2



South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10649</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>05/14/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ST WILLIAM'S CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>100 S 9TH ST MILBANK, SD 57252</b>
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S 236	<p>Continued From page 1</p> <p>hiring one of five (B) new employees. Findings include:</p> <p>1. Review of certified nursing assistant B's employee record revealed: *A hire date of 4/3/15. *The first step of the two-step TB test had been given 5/12/15. *That was not within the required two week time frame from having been hired.</p> <p>Interview on 5/13/15 at 3:30 p.m. with the director of nursing regarding the employee's record revealed she agreed the above employee's TB test had not been done in the required time.</p> <p>Review of the provider's 10/2/12 TB Control Plan policy revealed: **An initial two-step baseline screening at the time of employment for all employees in the facility and for all new admissions unless it has been done within the last 12 months, in which case, they will be given a one-step test." *No mention of a time frame to complete testing had been given.</p>	S 236	<p>The Director of Nursing (DON) and the Employee Health Nurse will monitor for the next 6 months that all new hires receive their TB test within the first two weeks of hire.</p> <p>The results will be reported to the QA &amp; A committee for the next 6 months.</p> <p><i>*The results will be reported by the DON or designee to the QA committee at the monthly leadership meeting for the next 6 months. NPN/SDDOH/MF</i></p>	
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