STATE VETERANS HOME PLAN OF CORRECTION – Norfolk State Veterans Home

DATE OF INSPECTION: March 10, 11, 12, 2008

STANDARD		DEFICIENCY	PLAN OF CORRECTIVE ACTION	SVH STAFF	EVIDENCE OF IMPROVEMENT	VA STAFF SIGNATURE	DATE	METHOD OF REVIEW
51.210 i,2,i	Medical Director is responsible for participating in establishing policies, procedures and guidelines to ensure adequate, comprehensive services	This is not met as evidenced by lack of a policy, procedure or guideline with relationship to Hospice agencies performing services in the State Veterans Home. Numerous issues were found regarding relationship with Hospice agency, i.e. monitoring and providing controled substances, changing necessary tubing timely. There are no clear lines of responsibility regarding what facility staff will do and what Hospice staff will do. Repeatedly asked for policy on Hospice. Pallative policy was provided, however, that does not cover Hospice services.	NVH does have Hospice Provider Agreements with Asera Care and Faith Regional Health Services (FRHS) Hospice that delineates duties. Both of these hospice agencies provide a hospice provider care plan for each member on hospice services, which is incorporated into the member's facility care plan. (See attached copies of Asera Care and FRHS hospice agreements). NVH will audit hospice care plans and NVH care plan, results taken to QI/QA for review and revision by 5/1/08. Completion date: 5/1/08	Tod Voss RoseAnn Ross Roz Phillips Kathy Brown Lew Mashburn				
51.210 j	Credentialing and privileging	This is provisionally met as evidenced by the absence of a statement that the individual is able to perform the services for the Medical Director, occupational therapist and physical therapist	The Medical Director and the physical therapist credentialing and privileging was completed prior to VA exit. The occupational therapist will be completed by April 28, 2008. The policy and forms for credentialing and privileging was changed this year. Annually and as licensure expires an audit will be conducted for completeness. These audits/summary will be taken to QI/QA for review. Completion date: 4/28/08	Tod Voss Lori Retzlaff Kathy Brown Lew Mashburn				

51.210 o	Clinical Records	The facility failed to maintain accurate documentation in the clinical record as evidenced by review of 26 charts. -Member # 21 had a skin flow sheet initiated on 2-16-08 for a Rt. Knee abrasion it was not documented when this area was healed. Skin flow sheet initiated on 2-18-08 for a Rt. outer elbow skin tear was not documented when this area was healed. -2 out of 26 charts reviewed had TB results and dates given documented. 24 of the charts had inadequate documentation for TB results. -Member # 21 had an order 2-17-08 for Blood Pressure and Pulse q shift x 1 month and report to M.D. Per the Vital Sign flow sheet this information was sporadically documented, this is difficult to assess due to documentation not being noted at an exact time. - Member # 22 had an order for weekly weights on 11-27-07. Weights were taken on 11-27-07, 12-11-07, 12-18-07, 1-2-08. Weeks 12-4-07 and 12-24-07 weights were not documented. -Member # 23 H&P lists allergies PCN and Sulfa. Sulfa allergy not printed on TAR, handwritten in on most of the MAR sheets. -Member # 17 inaccurate information listed on the nursing care plan goals review sheet stated member's last fall was 2-8-08 with abrasions to the knees no supportive documentation. Last fall was 2-6-08 with no injuries reported. - Member #10 inaccurate information on Vital Sign Flow sheet on weights dated 1-25-08 wt 174.3 lbs. 1-29-08 wt 193.2 lbs no re-weigh, 2-1-08 wt 191.8 lbs no re-weigh, 2-15-08 174.2 with re-weigh of 174.2.	Re-education will be provided to the nursing staff on following skin policy, following physician orders, monitoring completion of obtaining weights and re-weighing each member, adding interventions to care plans as incidents occur, computer data entry, notifying pharmacy of allergies. Pharmacy will be re-educated on computer entry of allergies. Member #21's skin flow sheet was documented on correctly on 3/10/08. Member #17's nursing care plan goal summary form for 2/8/08 was corrected on 4/3/08. Audits are completed after falls for inclusion into the member care plan, started 2/08. The weight policy will be reviewed, revised and implemented by 4/21/08. Weekly audits will be conducted for 3 months. All audits will be given to QI/QA for review and appropriate action. Completion date: 4/21/08	Roz Phillips Joe Mrsny Kathy Brown				
51.210 r	Transfer Agreement	This is not met as evidenced by the form that is completed when residents are transferred to the hospital does not include all necessary information. Facility transfer policy indicates that a patient transfer form will be completed, but this form is no longer being used as reported by two RNs and examination of 2 charts.	The current transfer data sent is the face sheet, current history and physical, MAR, TAR, POA forms, DNR form, and nursing referral form. Discussion was held with FRHS to assure the forms mentioned contained all the information needed	Joan Hult Roz Phillips				

			for them. They were happy with what is sent. The policy will be reviewed and revised to implement this current practice by 5/1/08. Completion date: 5/1/08.					
51.80 b	Notice of bed-hold policy and readmission	This was not met as evidenced by the facility is not providing written information regarding bed hold policy when transferring resident to the hospital.	The policy has been updated to include the explanation to the responsible party. Nursing and Social Work staff will be re-educated regarding reviewing with the member/legal representative the bed hold policy when leaving facility for pass/furlough/hospitalization by April 30, 2008. An audit will be completed monthly to monitor compliance with the bed hold policy. The results of these audits will be given to QI/QA for review and appropriate action. Completion date: 4/30/08	RoseAnn Ross Roz Phillips Kathy Brown				
51.90 c	Staff treatment of residents	This was not met as evidenced by a grievance written on 2-21-08 by Resident #27 with the aid of Staff RN #19 alleging that there was staff abuse. Grievance basically stated, went to bathroom, 2 staff (# 20 & 21) came in room to take to bathroom and resident said no, had already been. Was arguing and staff # 20 stated "they're going to send you to the nut house." Resident reached and pulled staff member's hair. They told me to stay in bed like "I was a little kid, when I told them I wanted to go to Bingo." The facility did not follow their policy for alleged abuse. The Administrator was not notified immediately and the situation had not been investigated at the time of this survey. The state had not been notified nor had the VA.	This grievance was investigated on February 29, 2008 when notified and re-investigated on March 17, 2008; no abuse or neglect was found. Grievances and alleged abuses will be discussed with Leadership staff daily as they are received, starting March 13, 2008. Re-education for all staff regarding NVH abuse and neglect policy by May 1, 2008. Completion date: 5/1/08	Lew Mashburn Roz Phillips Linda Sparr Rhonda Pettitt/Bev Anderson				

51.100 B, 3	Self-determination	This was not met as evidenced by review of the Grievance documentation, it was determined that there is a Sick Tray Policy that is inherently punitive regarding having clear liquids if unable to go to dining room to eat. In interviewing staff (ADON) she indicated that the policy had been written when facility was at old building to encourage residents to go to dining room for meals. The resident has the right to be sick, not feel good, be tired etc. and still receive his/her ordered diet. They have the right to self determination to make choices about aspects of his or her life in the facility that is significant to resident. Eating meals is significant to most individuals. The resolution to the Grievance was to rewrite the policy, which had not been done at time of survey.	The sick tray policy has been discontinued. A new room tray policy has been established; nursing leadership has been trained and will educate all nursing staff by April 30, 2008. Dietary staff were educated on this policy change on 3/25/08. The member will be given a copy of the revised policy by 4/14/08. Completion date: 4/30/08	Joan Hult Joe Mrsny Roz Phillips Lew Mashburn				
51.110 d	Comprehensive care plans	The facility failed to keep care plans current as evidenced by review of 26 charts and the findings stated below: -Member #10 care plan had outdated information regarding stolen money from 7-30-07. Also noted a diet change from Mech. Soft with thickened liquids to Mech. Soft with thin liquids on 2-13-08 not reflected in care plan -Member #16 had an order for physical therapy for 2-4-08 which was d/cd on 2-28-08. He was transferred to restorative care on 2-28-08; these items were not reflected in the care plan. -Member # 11 diet order was Mech. Soft diet with Nectar thick liquids it was changed on 3-9-08 to a Pureed diet with nectar thick liquids. The care plan did not reflect this change. -Member # 2 diet order was Regular diet changed on 1-18-08 to Pureed diet with nectar thick liquids. Member also had Pulmocare between meals, Pro Cal BID and Resource TID not on care plan. -Member # 18 11-14-07 Mech. Soft Diet with nectar thick liquids also had bolus tube feeding. 12-4-07 bolus tube feeding changed to over night feed with pump. 2-8-08 diet changed to	All care plans on these members have been updated. The nursing staff have been re-educated to update the care plan as orders are processed. The Interdisciplinary team has been re-educated to update care plans as changes in their area of the care plan occur. An audit will be completed weekly on all orders received for inclusion/resolution in the care plan. The results of these audits will be given to QI/QA for review and appropriate action. Completion date: 5/14/08	RoseAnn Ross Joe Mrsny Kate Reiners Glenda McGrew Kim Benson Pam Hannappel Kathy Brown				

		regular diet with thin liquids. None of this information was reflected in the care plan.						
51.120 b	Activities of daily living	The facility failed to follow their policy and to ensure member safety during transfer in a sit/stand lift as evidenced by observation of transfer on unit D on 2-31-08. -Staff members #18 and #8 were transferring a member per the sit/stand lift. They did not fasten the belt buckle around him and repeatedly cued him to hang onto the handle of the lift. The safety belt that goes around the legs was not applied either. Upon interview of staff member #4 it was stated that they don't usually fasten the belt because they use 2 people to transfer.	All nursing staff will be re-educated by 4/30/08. All nursing direct care staff will complete a competency review on mechanic lifts by 5/14/08. An audit will be conducted weekly x 3 weeks with results to QI/QA for review and appropriate action. Completion date: 5/14/08	Roz Phillips Kathy Brown Rhonda Pettitt/Bev Anderson				
51.120 g	Mental and Psychosocial functioning	This was not met as evidenced by the following. 1. Documentation in the Social Work Notes of Resident #25 identifies him as desiring to return home when achieves strength needed. Although this is a theme throughout his documentation there is no current discharge plan. A psychosocial need of wanting to go home/lack of acceptance of current placement without attempting to meet or resolve need. 2. Resident # 21 has behaviors identified numerous times on the behavior tracking sheet, resistance to cares, cause - soiled clothing, intervention of redirect or 1-1's with the consistent outcome of no change. No documented evidence of reviewing data gathered, and attempting different interventions to produce a different outcome.	#25's care plan addresses the desire to return home. The Interdisciplinary team will be re-educated to capture the new interventions from the care plan to the "Intervention Code" section of the behavior monitoring record so staff can document on effectiveness of the interventions by May 14, 2008. An audit of each member's behavior monitoring record will be conducted monthly x 2, then quarterly with results taken to QA/QI for review and appropriate action. Completion date: 5/14/08	RoseAnn Ross Joe Mrsny Kate Reiners Joan Hult Roz Phillips Kathy Brown Pam Hannappel Glenda McGrew Kim Benson					
51.120 h	Enteral Feedings	-Observed staff member # 13 administer g-tube meds to member #9 without checking residual and placement prior to medication administration. -Member #9 on February 25th and	Licensed nurses will be re-educated and competency tested by May 1, 2008 on checking g-tube placement and residuals with	Roz Phillips				

		26th evening shift residuals were 200 and 180cc. Per policy if residuals are greater than 150cc they are to stop the feeding times 1 hour and then re-check residual level. No documentation noted to support that the residuals were ever retaken or that the tube feeding had been stopped for 1 hour and restarted.	documentation. An audit will be conducted quarterly with results taken to QA/QI for review and appropriate action. Completion date: 5/14/08					
51.120 I	Accidents	The facility failed to keep the resident environment free of possible hazards as evidenced by observations made during the facility tour on 3-10-08. - Room D126 noted to have Oxygen tubing 32 feet long from concentrator going into the bathroom creating a safety hazard and increased risk of falls. - Noted several rooms during facility tour with 32 ft long oxygen tubing connected to the concentrator and ran into the bathroom. -Noted on tour of restorative room that there was a cord plugged into the wall that was attached to a piece of exercise equipment. The cord stretched from the equipment across the floor causing a trip hazard.	The members that have this as a problem do not want their oxygen concentrators in their rooms due to the noise and added heat to their room so the concentrator is in the member's bathroom. The oxygen concentrators will be moved next to members' beds with shorter oxygen tubing provided by 4/18/08. The cord to the exercise equipment has had a cord protector applied on 3/11/08. The Rehab room was rearranged on 4/4/08 to prevent the cord trip hazard. Completion date: 4/18/08	Jeff Rethwisch Roz Phillips				
51.120 J	Nutrition	Standard J.1. This was not met as evidenced by the nursing policy on weighing members is not consistently followed in the facility. The nursing policy and procedure for documenting weights states that members with a gain or loss of >5 lb. from the previous recorded weight must be reweighed. During record reviews of the past 6 months this surveyor found 7 of 10 members had not been consistently reweighed when a weight change of +/- 5 lbs. had been recorded. Records include #16, #18, #7, #1, #11, #9, and #10.	The weight policy will be reviewed, revised and implemented by 4/21/08. Weekly audits will be conducted for 3 months. All audits will be given to QI/QA for review and appropriate action. Completion date: 4/21/08	Roz Phillips Joe Mrsny Kathy Brown				
51.120 L	Special Needs	The facility failed to ensure the members received proper treatment or	All nursing staff will be re-educated by 4/30/08 on cath care,	Roz Phillips Kathy Brown				

		care in the following special service areas as evidenced by observation of cares throughout the facility. -Catheter care completed by staff member #11- was noted to have cleansed around meatus for foley catheter cares and then wiped down the tubing and then wiped back up toward the meatus with the same cloth. -Suprapubic catheter cares- staff member #11 was noted to spray skin cleanser directly on the resident around the suprapubic catheter site then took the 4x4 and wiped around the site. Suprapubic catheter cares were observed on 3-11-08 staff members # 4 and # 5 provided the cares. The member was left fully clothed and sitting in an upright position in his w/c. Staff member # 4 pulled down member's pants from the waistband just far enough to cleanse the site area. She had used a wet 4x4 to go around the site area but did not go down the catheter. With member being in a sitting position it was very difficult to have full access to the area to get the area cleansed thoroughly. Staff member # 5 had ointment on an applicator and proceeded to pull pants away from site and rubbed ointment all around base of catheter at site. -Respiratory care: Humidified O2 not changed every 30 days as per policy as noted in rooms F124 and B108. - Those members on hospice, the humidified water bottle and O2 tubing were not dated. DON reports that it is their policy that hospice manages the O2 and supplies. The Palliative Care Policy does not state that it is the responsibility of Hospice to manage the O2, supplies and the weekly scheduled changes. -Oxygen tubing noted to be not dated throughout facility as well as nebulizer treatment tubing in rooms E 147B and E 143 and 1 suction machine tubing dated 9-10-07 in room #130A. Oxygen tubing on E-tank in room D103 was dated 2-7-08; the oxygen tubing on the concentrator in the same room was not dated. Room D109A oxygen tubing not dated. Room D126 oxygen tubing dated 2-7-08. Room	suprapubic care, and infection control regarding respiratory equipment. All nursing direct care staff will complete a competency review on catheter care by 5/14/08. An audit will be conducted weekly x 3 weeks, then quarterly with results to QI/QA for review and appropriate action. A monthly audit is being completed for O2 humidification and tubing changes with dates, starting 4/1/08. The results will be given to QI/QA for review and appropriate action. Completion date: 5/14/08				

		D122 oxygen tubing dated 2-7-08.					
51.120 M, 2	Antipsychotic drugs	Member #28 has three orders for psychotropic medications. Abilify with the target behavior of urinating in peers room, Namenda with target behavior of punching/yelling at staff, and Seroquel with the target behavior of disrobing in public. Behavior documentation does not indicate that the member has displayed any of these behaviors recently and staff member #14 stated that he had not had any of these behaviors in a "long time". All three medication orders originate from June and July of 2006 without a documented gradual dose reduction for either medication. The facility lacks a process for gradual dose reduction of psychotropic medications. Member #29 had eight orders for changes in psychotropic medications due to lethargy. All orders were written on 3/4/08 to start on 3/5/08. At time of survey, behavior log had not been updated with medication changes and nursing notes or behavior log lacked documentation in regard to medication changes and improvement or decline in symptoms.	Medication reviews are conducted monthly by the Pharmacist with follow-up review by the physician. Quarterly psychotropic medication reviews/behaviors are also conducted. An audit is being conducted quarterly to review diagnosis. psychotropic medications and how long the member has been on the medication. This audit will be shared with the Medical Director and QI/QA for review and appropriate action. The Medical Director will be re-educated regarding VA interpretation 51.120 (M), (2), (ii). The behavior on #29's behavior monitoring log was changed to include the medication change on 3/11/08. Nursing staff have been re-educated on changing medications on the behavior form and documentation by 4/30/08. An audit will be completed monthly after pharmacy reviews starting April 2008 on the pharmacy review process. The results will be given to QI/QA for review and appropriate action. Completion date: 5/1/08	Tod Voss Pam Hannappel Lew Mashburn Lori Retzlaff Roz Phillips Kathy Brown			
			All outdated items	Roz Phillips			

51.120 N	Medication errors	The facility failed to provide strategies for preventing medication errors and adverse reactions as evidenced by observations made during facility tour on 3-10-08. -Noted on unit C supply room 127-expired petroleum jelly as of 04-07. Also noted expired duoderm in 2006. - Unit C medication refrigerator found a bottle of unopened 70/30 insulin with a sticky note stating borrowed for one member from another member. -Member # 26 narcotic oxycodone prn package had been marked with a black sharpie, routine, tape had been placed across the back of several bubble openings. The routine package had been labeled with a black sharpie "PRN". -Unit F cupboard outside isolation room an open distilled water container dated 3-11-06. In room #D147 2 jugs of distilled water were found 1 dated 10-22-07 and the other dated 1-4-08 both were open. In room D129 a bottle of Guiatuss cough syrup was open and dated 1-15-08 and a bottle of Kaopectate opened 2-2-08 with an expiration date of 1-08. In room E120 2 cartons of Italian ice out dated 1-18-08 and 1-20-08 were found in the refrigerator. Also noted in room E120 that a family had brought in a dietary supplement for kids that had expired on 9-05 - QA Coordinator stated they would contact the family and have them remove it this was on 3-10-08. On 3-11-08 upon return to the nurse documentation room the dietary supplement for kid's expiration 9-05 was sitting out on the table. The QA Coordinator again stated it was going to be sent back to the family but there was no note on it to instruct other staff not to give to the member. On 3-11-08 observed staff member #8 administering eye drops without wearing gloves. Per facility policy gloves are to be worn during administration of eye drops. During observed med pass staff member #1 did not document on member #30 MAR until after another member #31 had received medications. Member #28 Miralax was measured incorrectly; Prevacid solutab was	have been removed and discarded by 3/11/08. The supplement brought in by family for member in E120 was removed from the kitchenette and was sitting in the nursing workroom by the phone. Nursing staff were making an attempt to contact the family for disposal of this supplement. A note was attached to the container to not to use supplement. Supplement was given to member's family. The oxycodone label was replaced on 3/11/08. Medications are no longer borrowed from one member to another effective 3/11/08. A monthly audit is completed checking for outdated supplies and medications, starting March 2008. The results will be given to QI/QA for review and appropriate action. Cited individuals have been re-educated and competencies checked on 6 rights of medication administration on 3/11/08. Licensed nurses and medication aides will be re-educated on the six rights of medication with competencies monitored by 4/30/08. Medication pass audits will be conducted weekly x	Kathy Brown NVH Pharmacist				

		crushed and put in pudding while the order stated to give with 10cc of water 30 minutes prior to a meal. Medications were not administered to member #28 as he was at physical therapy, prepared medications left on counter unattended. Member #29 Prevacid solutab was crushed put in pudding and administered at 0850 while the order stated to dissolve in 10cc of water 30 minutes prior to a meal. Member #32 Prevacid solutab was dissolved in an unknown amount of water and administered at 0900 while the order stated to dissolve in 10cc of water 30 minutes prior to a meal. One medication error report was marked with white out while others lack signatures of nurse executive or physician, or employee. -Room E146B had a water pitcher with regular water in it sitting next to a sign posted that stated Honey Thickened Liquids -Room E129A had a water pitcher with regular water in it sitting next to a sign posted that stated Nectar Thick Liquids	3, then quarterly with results given to QI/QA for review and appropriate action. Staff will be re-educated regarding not using white out by 4/30/08. Those med errors lacking signatures were from pharmacy errors. The pharmacist signs one copy while the nurse executive and medical director sign the original with both copies left in file. An audit is conducted with each error received for completion. The results will be given to QI/QA for review and appropriate action. The fluid policy will be revised to include removing the water pitcher from those members on altered liquid consistencies and will be replaced with the appropriate individual servings of thickened liquid by 4/30/08. The water pitchers have currently been removed. Staff was re-educated regarding water pitchers and appropriate liquid consistencies. An audit will be completed monthly x 3 then quarterly. The results will be given to QI/QA for review and appropriate action. Completion date: 4/30/08						
			Dietary staff will be	Joe Mrsny					

		>15 seconds under warm water but used the back of her hand to turn off faucet handle before drying her hands.	daily audit was conducted x 2 weeks on every dietary staff member, followed by weekly audits on every dietary staff member x 3 months. The results of these audits will be given to QI/QA for review and appropriate action. Completion date: 4/7/08					
51.180 A	Procedures	Facility has an established process of nurse initiated 'borrowing" of medications from one member to give to another member after pharmacy hours. This system of borrowing is evidenced by a request for pharmacy supplies form designed to document the exchange and replenish the borrowed stock. Additionally the pharmacy maintains a spreadsheet of what medication was borrowed and when it was replaced. This process has contributed to at least one documented medication error in the past 2 months.	Medications are no longer borrowed from one member to another effective 3/11/08. Completion date: 3/11/08	NVH Pharmacist Roz Phillips				
51.180 d.	Labeling of drugs and biologicals	Member #26, oxycodone PRN packaged marked "routine" in black marker, and routine package marked "PRN" in black marker.	The oxycodone label was replaced on 3/11/08. Completion date: 3/11/08	NVH Pharmacist Roz Phillips				
51.190	Infection control	The facility failed to maintain an infection control program designed to prevent the development and transmission of disease and infection. -Bath house F - blue tub seat noted to have a crack that is not a cleanable surface. Bath house D - noted broken tile on floor near tub. -During med pass observation it was noted that staff member #6 was using applesauce in the original jar, used an ungloved had to spoon out of the open jar of applesauce enough sauce for her to use in a 1x med pass. Applesauce jar was dated 2-6-08 - per ADON the date represented the date it came into the facility. There was no date on the jar telling when it had been opened. -The brown leather chairs throughout	A new whirlpool seat for the lift has been ordered and will be installed when received. The floor tile in Unit D was repaired 4/9/08. NVH will obtain individual serving applesauce for medication pass. The individual has been re-educated on infection control techniques. An audit will be conducted to monitor dating opened containers	Jeff Rethwisch Kathy Brown Roz Phillips				

		the facility especially noted in B, C,D, E lounges were worn down to cloth and are now uncleanable surfaces.	weekly x 3, then quarterly. The results will be given to QI/QA for review and appropriate action. The recliners will be ordered and others replaced upon receipt of new recliners by 5/14/08. Completion date: 5/14/08					
51.200	Physical Environment	The automatic extinguishing system over the fryers did not shut off all sources of fuel and heat to the equipment protected by the system. NFPA 96-2004 10.4.1 this is a repeat from last year.	A Goodwin Tucker representative assessed the system on 4/9/08 with repairs to follow with completion expected by 5/14/08 Completion date: 5/14/08	Jeff Rethwisch				
51.200 c.	Space and equipment	During facility tour in the main kitchen a surveyor noted a heavy buildup of ice by the fan/compressor in the walk-in freezer. The surveyor also noted a heavy buildup of ice in a freezer in kitchenette D/E. The facility failed to maintain all essential patient care equipment in safe operating condition as evidenced by observations made during facility tour on 3-10-08. -EZ belt on E unit by the smoke room was dated 9-05. The contact points of the straps located at the base of the belt were starting to tear on both sides. According to facility procedure on Lifts: Inspection of slings and belts: 1. Slings and belts will be inspected before every use for wear and tear. 2. Slings and belts will be replaced two years from service date or depending on the wear and tear or discoloration of the sling/belt. 3. Warranty tag-even if the sling/belt appears to be in good condition, look at the date punched on the warranty tag and if over two years, the sling/belt should be replaced. Tag date was 2007. -On the D unit not all lift belts were dated. All tag dates observed were 2007.	The seams around the walk-in freezer are cracked and will be repaired by 4/25/08. The D/E freezer will be fixed by April 18, 2008. The EZ belt with tears was changed on March 10, 2008. An audit will be completed monthly to monitor belt repair and dates put into use. The results of these audits will be given to QI/QA for review and appropriate action. Completion date: 4/25/08	Jeff Rethwisch Joe Mrsny Roz Phillips Kathy Brown				

Did the SVH submit CAP within 10 days? _____Yes _____No

Approve / Disapprove

Full Certification Provisional Certification