

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157647	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  INDEPENDENCE HOME HEALTH LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 7443 BEECH TREE RD NINEVEH, IN 46164
--	--

(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
--------------------	--	---------------	---	----------------------

G000000	<p>This was a federal home health complaint investigation survey.</p> <p>Complaint # IN00153796 - Substantiated: Federal deficiencies related to the allegation are cited. An unrelated deficiency was also cited.</p> <p>Survey Dates: September 17-19, 2014</p> <p>Facility #: 012830</p> <p>Medicaid # 201079480</p> <p>Surveyor: Nina Koch, RN, PHNS</p> <p>Census: 21 active skilled nursing patients</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN October 9, 2014</p>	G000000		
G000157	484.18			

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

TITLE

(X6) DATE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157647	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/17/2014
NAME OF PROVIDER OR SUPPLIER  INDEPENDENCE HOME HEALTH LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 7443 BEECH TREE RD NINEVEH, IN 46164		
(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	
	<p>ACCEPTANCE OF PATIENTS, POC, MED SUPER</p> <p>Patients are accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately by the agency in the patient's place of residence.</p> <p>Based on clinical record review and interview, the home health agency failed to ensure enough staff were employed to meet patient needs for 1 (#3) of 3 clinical records reviewed with the potential to affect all of the agency's 21 patients.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>Clinical record # 3 included a plan of care established by the patient's physician for the certification period 7/26/2014 through 9/23/2014 with orders for skilled nursing visits effective the week of 9/26/2014 one day for week one and 7 days a week for 8 weeks. The clinical record failed to evidence skilled nursing was provided 8/2/2014, 8/3/2014, 8/16/2014, 8/23/2014, 8/30/2014, and 9/6/2014. The documentation stated, "No nurse available, patient notified, patient states mother will provide care."</li> <li>On 9/19/2014 at 1 PM, patient #3 indicated there were numerous dates when care was not provided. A family member assisted with her care on those</li> </ol>	G000157	<p>G-0157 In the last 23 days our agency has hired 4 additional skilled nursing; one (1) Part-time and three (3) PRN, to ensure adequate staff for when full time staff not available,</p> <p>The clinical director will review 100% of future intake/referrals to ensure adequate staffing to meet patient's nursing needs according to referral request of services, The agency has implemented a place on the intake sheet for the clinical director to approve or disapprove the agency accepting the referral,</p> <p>The Clinical Director will be responsible for monitoring the above corrective actions to ensure this deficiency will not recur</p>	10/14/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157647		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/17/2014	
NAME OF PROVIDER OR SUPPLIER  INDEPENDENCE HOME HEALTH LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 7443 BEECH TREE RD NINEVEH, IN 46164			
(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			
G000158	<p>dates. Family member has health problems also and had been advised against transferring and lifting the patient.</p> <p>3. On 9/18/2014 at 3:30 PM, the agency administrator indicated skilled nursing visits were not provided as ordered in the plan of care.</p> <p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</p> <p>Based on clinical record review and interview, the home health agency failed to ensure skilled nursing services were provided in accordance with the plan of care for 1 (#3) of 3 clinical records reviewed with the potential to affect all of the agency's 21 patients receiving skilled nursing services.</p> <p>Findings:</p> <p>1. Clinical record # 3 included a plan of care established by the patient's physician for the certification period 7/26/2014 through 9/23/2014 with orders for skilled nursing visits effective the week of</p>	G000158	G-0158 The clinical director and administrator has inserviced the case manager and office support members, (scheduler) the regulation, policy and procedure on following the established plan of care, this has included: evaluating and re-evaluating services for the frequency of skilled nursing are followed and changes are noted with physician interim orders when necessary and those interim orders are followed, In addition, education on documenting of continual attempts to comply with frequency of visits as outlined on the plan of care, The clinical Director has audited 100% of all active patients to ensure services are being provided according to the	10/14/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157647	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  INDEPENDENCE HOME HEALTH LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 7443 BEECH TREE RD NINEVEH, IN 46164
--	--

(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
G000170	<p>9/26/2014 one day for week one and 7 days a week for 8 weeks. The clinical record failed to evidence skilled nursing was provided 8/2/2014, 8/3/2014, 8/16/2014, 8/23/2014, 8/30/2014, and 9/6/2014. The documentation stated, "No nurse available, patient notified, patient states mother will provide care."</p> <p>2. On 9/19/2014 at 1 PM, patient #3 indicated there were numerous dates when care was not provided. A family member assisted with her care on those dates. Family member has health problems also and had been advised against transferring and lifting the patient.</p> <p>3. On 9/18/2014 at 3:30 PM, the agency administrator indicated skilled nursing visits were not provided as ordered in the plan of care.</p> <p>484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care.</p>		<p>frequency and duration of skilled nursing services, this deficiency has been corrected as of 10-10-2014, 10% of all the clinical records will be audited every month for three (3) months then quarterly for above compliance, The Clinical Director will be responsible for monitoring the corrective action to ensure this deficiency will not recur</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157647		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/17/2014	
NAME OF PROVIDER OR SUPPLIER  INDEPENDENCE HOME HEALTH LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 7443 BEECH TREE RD NINEVEH, IN 46164			
(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			
	<p>Based on clinical record review and interview, the home health agency failed to ensure skilled nursing services were provided in accordance with the plan of care for 1 (#3) of 3 clinical records reviewed with the potential to affect all of the agency's 21 patients receiving skilled nursing services.</p> <p>Findings:</p> <p>1. Clinical record # 3 included a plan of care established by the patient's physician for the certification period 7/26/2014 through 9/23/2014 with orders for skilled nursing visits effective the week of 9/26/2014 one day for week one and 7 days a week for 8 weeks. The clinical record failed to evidence skilled nursing was provided 8/2/2014, 8/3/2014, 8/16/2014, 8/23/2014, 8/30/2014, and 9/6/2014. The documentation stated, "No nurse available, patient notified, patient states mother will provide care."</p> <p>2. On 9/19/2014 at 1 PM, patient #3 indicated there were numerous dates when care was not provided. A family member assisted with her care on those dates. Family member has health problems also and had been advised against transferring and lifting the patient.</p>	G000170	G-0170 The Clinical Director and administrator has inserviced the case manager and office support members (scheduler) the regulation, policy and procedure on furnishing skilled nursing services accordance with the written Plan of Care, This has included evaluating and reevaluating services for the frequency of skilled nursing are followed and changes are noted with physician interim orders when necessary and those interim orders are followed, In addition, education on documenting of continual attempts to comply with frequency of visits as outlined on the plan of care, The Clinical Director has audited 100% of all active patients to ensure services are being provided according to the frequency and duration of skilled services, this deficiency has been corrected as of 10-10-2014, 10% of the clinical records will be audited monthly x3months for above compliance then quarterly for above compliance, The Clinical Director will be responsible for monitoring the corrective action to ensure this deficiency will not recur	10/14/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157647	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/17/2014
NAME OF PROVIDER OR SUPPLIER  INDEPENDENCE HOME HEALTH LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 7443 BEECH TREE RD NINEVEH, IN 46164		
(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	
N000000	<p>3. On 9/18/2014 at 3:30 PM, the agency administrator indicated skilled nursing visits were not provided as ordered in the plan of care.</p> <p>This was a state home health complaint investigation survey.</p> <p>Complaint IN00153796 - Substantiated: .State deficiencies related to the allegation are cited. An unrelated deficiency was also cited.</p> <p>Survey Dates: September 17-19, 2014</p> <p>Facility #: 012830</p> <p>Medicaid # 201079480</p> <p>Surveyor: Nina Koch, RN, PHNS</p> <p>Census: 21 active skilled nursing patients</p> <p>Quality Review: Joyce Elder, MSN,</p>	N000000			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157647		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/17/2014	
NAME OF PROVIDER OR SUPPLIER  INDEPENDENCE HOME HEALTH LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 7443 BEECH TREE RD NINEVEH, IN 46164			
(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			
N000520	<p>BSN, RN October 9, 2014</p> <p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Patients shall be accepted for care on the basis of a reasonable expectation that the patient's health needs can be adequately met by the home health agency in the patient's place of residence.</p> <p>Based on clinical record review and interview, the home health agency failed to ensure enough staff were employed to meet patient needs for 1 (#3) of 3 clinical records reviewed with the potential to affect all of the agency's 21 patients.</p> <p>Findings:</p> <p>1. Clinical record # 3 included a plan of care established by the patient's physician for the certification period 7/26/2014 through 9/23/2014 with orders for skilled nursing visits effective the week of 9/26/2014 one day for week one and 7 days a week for 8 weeks. The clinical record failed to evidence skilled nursing</p>	N000520	<p>N-0520 In the last 23 days our agency has hired four (4) additional skilled nursing, one (1)Part-time and three (3) PRN, to ensure adequate staff for when full time staff not available, The Clinical Director will review 100% of future intake/referrals to ensure adequate staffing to meet patients nursing needs according to referral request of services The Agency has implemented a place on the intake sheet for the clinical director to approve or disapprove the agency accepting the referral, The clinical director will be responsible for monitoring the above corrective action to ensure this deficiency will not recur</p>	10/14/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157647	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  INDEPENDENCE HOME HEALTH LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 7443 BEECH TREE RD NINEVEH, IN 46164
--	--

(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
N000522	<p>was provided 8/2/2014, 8/3/2014, 8/16/2014, 8/23/2014, 8/30/2014, and 9/6/2014. The documentation stated, "No nurse available, patient notified, patient states mother will provide care."</p> <p>2. On 9/19/2014 at 1 PM, patient #3 indicated there were numerous dates when care was not provided. A family member assisted with her care on those dates. Family member has health problems also and had been advised against transferring and lifting the patient.</p> <p>3. On 9/18/2014 at 3:30 PM, the agency administrator indicated skilled nursing visits were not provided as ordered in the plan of care.</p> <p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on clinical record review and interview, the home health agency failed to ensure skilled nursing services were provided in accordance with the plan of care for 1 (#3) of 3 clinical records reviewed with the potential to affect all of the agency's 21 patients receiving skilled nursing services.</p>	N000522	N-0522 The clinical director and administrator has inserviced the case manager and office support members, (scheduler) the regulation, policy and procedure on following the established plan of care, this has included: evaluating and re-evaluating services for the frequency of skilled nursing are followed and	10/14/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157647		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/17/2014	
NAME OF PROVIDER OR SUPPLIER  INDEPENDENCE HOME HEALTH LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 7443 BEECH TREE RD NINEVEH, IN 46164			
(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			
	<p>Findings:</p> <p>1. Clinical record # 3 included a plan of care established by the patient's physician for the certification period 7/26/2014 through 9/23/2014 with orders for skilled nursing visits effective the week of 9/26/2014 one day for week one and 7 days a week for 8 weeks. The clinical record failed to evidence skilled nursing was provided 8/2/2014, 8/3/2014, 8/16/2014, 8/23/2014, 8/30/2014, and 9/6/2014. The documentation stated, "No nurse available, patient notified, patient states mother will provide care."</p> <p>2. On 9/19/2014 at 1 PM, patient #3 indicated there were numerous dates when care was not provided. A family member assisted with her care on those dates. Family member has health problems also and had been advised against transferring and lifting the patient.</p> <p>3. On 9/18/2014 at 3:30 PM, the agency administrator indicated skilled nursing visits were not provided as ordered in the plan of care.</p>		<p>changes are noted with physician interim orders when necessary and those interim orders are followed, In addition, education on documenting of continual attempts to comply with frequency of visits as outlined on the plan of care, The clinical Director has audited 100% of all active patients to ensure services are being provided according to the frequency and duration of skilled nursing services, this deficiency has been corrected as of 10-10-2014, 10% of all the clinical records will be audited every month for three (3) months then quarterly for above compliance,</p> <p>The Clinical Director will be responsible for monitoring the corrective action to ensure this deficiency will not recur</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157647	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  INDEPENDENCE HOME HEALTH LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 7443 BEECH TREE RD NINEVEH, IN 46164
--	--

(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
N000537	<p>410 IAC 17-14-1(a) Scope of Services Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows:</p> <p>Based on clinical record review and interview, the home health agency failed to ensure skilled nursing services were provided in accordance with the plan of care for 1 (#3) of 3 clinical records reviewed with the potential to affect all of the agency's 21 patients receiving skilled nursing services.</p> <p>Findings:</p> <p>1. Clinical record # 3 included a plan of care established by the patient's physician for the certification period 7/26/2014 through 9/23/2014 with orders for skilled nursing visits effective the week of 9/26/2014 one day for week one and 7 days a week for 8 weeks. The clinical record failed to evidence skilled nursing was provided 8/2/2014, 8/3/2014, 8/16/2014, 8/23/2014, 8/30/2014, and 9/6/2014. The documentation stated, "No</p>	N000537	N-0537 The Clinical Director and administrator has inserviced the case manager and office support members (scheduler) the regulation, policy and procedure on furnishing skilled nursing services accordance with the written Plan of Care This has included evaluating and reevaluating services for the frequency of skilled nursing are followed and changes are noted with physician interim orders when necessary and those interim orders are followed, In addition, education on documenting of continual attempts to comply with frequency of visits as outlined on the plan of care, The Clinical Director has audited 100% of all active patients to ensure services are being provided according to the frequency and duration of skilled services, this deficiency has been corrected as of 10-10-2014, 10% of the clinical records will be audited monthly x3months for	10/14/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157647	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/17/2014
NAME OF PROVIDER OR SUPPLIER  INDEPENDENCE HOME HEALTH LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 7443 BEECH TREE RD NINEVEH, IN 46164		
(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	
	<p>nurse available, patient notified, patient states mother will provide care."</p> <p>2. On 9/19/2014 at 1 PM, patient #3 indicated there were numerous dates when care was not provided. A family member assisted with her care on those dates. Family member has health problems also and had been advised against transferring and lifting the patient.</p> <p>3. On 9/18/2014 at 3:30 PM, the agency administrator indicated skilled nursing visits were not provided as ordered in the plan of care.</p>		<p>above compliance then quarterly for above compliance, The Clinical Director will be responsible for monitoring the corrective action to ensure this deficiency will not recur</p>		