

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

PRINTED: 01/03/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185194	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/16/2011
NAME OF PROVIDER OR SUPPLIER THE FORUM AT BROOKSIDE			STREET ADDRESS, CITY, STATE, ZIP CODE 200 BROOKSIDE DRIVE LOUISVILLE, KY 40243	
(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	F 000		
F 156 SS=C	<p>A standard health survey was conducted 12/14/11 through 12/16/11 and a Life Safety Code survey was conducted 12/14/11. Deficiencies were cited with the highest scope and severity of an "F" with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition.</p> <p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p>	F 156	<p>F156 483.10(b)(1) Notice of Rights, Rules, Services, Charges</p> <p>Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with federal and state law.</p> <p>Corrective Action for Residents Cited by Deficient Practice With respect to the residents cited, there were no residents cited.</p> <p>Identification of Other Facility Residents that may be affected by the deficient practice With respect to how the facility will identify residents with the potential for the identified concern and take corrective action, The Director of Admissions will ensure that all residents receive, in writing, upon admission, information regarding their rights as</p>	01/20/12

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

[Signature]

TITLE

[Signature]

(X6) DATE

1/13/12

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.

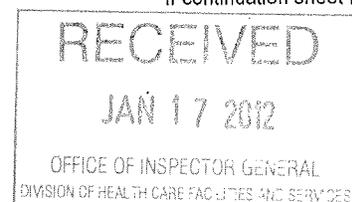
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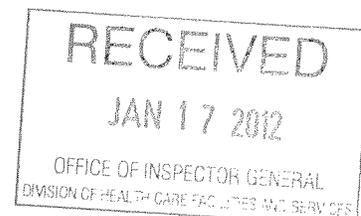
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F 156	<p>Continued From page 1</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements</p>	F 156	<p>resident of a long-term care facility and how to apply for and use Medicare and Medicaid benefits. Director of Admissions will ensure that all residents understand that the information is available for review in an area of the facility where it is prominently displayed. On 01/12/12, the Administrator will provide this information to residents and family members through a mailing.</p> <p>Implementation of Systemic Measures With respect to what systemic measures have been put in place to address that stated concern, The Administrator has secured, through the state licensing agency, copies of the appropriate documentation to be prominently displayed within the facility. Facility Administrator will provide information regarding their rights as resident of a long-term care facility and how to apply for and use Medicare and Medicaid benefits, through bi-annual resident and family meetings conducted each spring and fall.</p> <p>Monitoring of Corrective Action With respect to how the plan of corrective measures will be monitored, The Administrator through a quarterly audit, will ensure the information is predominantly displayed in facility and distributed to the residents and families on bi-annual meeting/mailing.</p>	



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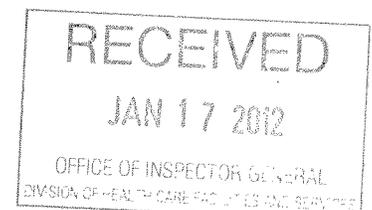
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F 156	Continued From page 2 specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to prominently display in the facility how to apply for and use Medicare and Medicaid benefits. The findings include: Observation made during the environment tour, on 12/16/11 at 11:00 AM, revealed no display of Medicare and Medicaid benefits. Observations made with the Activities Director and Assistant	F 156		



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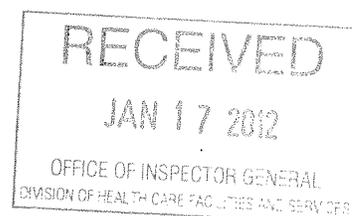
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F 156	Continued From page 3 Director of Nursing, revealed they were unable to find a Medicare and Medicaid display. Interview with the Director of Nursing (DON), on 12/16/11 at 12:30 PM, revealed she was not aware there was a posting for Medicare and Medicaid benefits, though each resident received information on Medicare and Medicaid benefits upon admission. Interview with the Administrator, on 12/16/11 at 2:00 PM, revealed he was not aware the Medicaid and Medicare benefits should be posted in the facility.	F 156		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policy, it was determined the facility failed to serve, prepare, and distribute food under sanitary conditions. Tray line food was handled with contaminated gloved hands, and staff failed to wash hands between glove changes. Two (2) staff members were observed in the kitchen without use of required hair coverings. Multiple	F 371	F371 483.35(i) Food Procure, Store, Prepare, Serve – Sanitary Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with federal and state law. Corrective Action for Residents Cited by Deficient Practice With respect to the residents cited, The Food & Beverage Director presented all Kitchen staff in-service training, on 12/16/11, regarding the proper storage of brooms, proper hand washing techniques and use of gloves, and hairnet requirement usage within the food production kitchen area. On 01/12/12 the Food and Beverage Director held an	01/20/12



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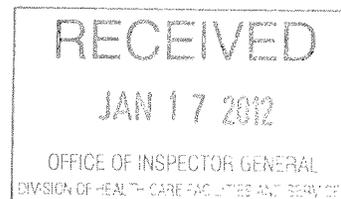
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F 371	Continued From page 4 brooms were stored with bristles on the floor. The findings include: Review of the facility's policy for Food Safety detailed that food was prepared in a sanitary manner with minimal handling and avoidance of touching ready-to-eat foods with the hands, and stated all staff, visitors, or inspectors of the kitchen were required to wear appropriate hair covering during normal food production hours. Review of the facility policy for Handwashing revealed hands were to be washed after contact with soiled or contaminated articles, and after removal of gloves. Review of the facility policy for Environment of Care: Storage Spaces revealed mops and brooms should be stored off of the floor, rather than standing on their bristles. Observation, on 12/15/11 at 11:35 AM, revealed the AM Cook used gloved hands to turn servings of meat during food temperature readings. The AM Cook use a gloved hand to pick up and dispose of a condiment that dropped onto the floor, then removed one (1) glove and washed that hand and returned to serve food on the tray line. The AM Cook was observed to reach into a pants pocket, then reach into the hair behind the head while looking for a pen, then the AM Cook discarded the gloves and put on clean gloves without handwashing. The AM Cook was observed to remove a glove which was stored in a pants pocket. The AM Cook was observed to touch the inside of a garbage disposal bin with gloved hands, then removed the gloves and put on clean gloves without handwashing. Observation, on 12/16/11 at 1:00 PM, revealed a	F 371	individual in-service training session with the AM cook regarding the policies for handling of food products, appropriate use of gloves and proper technique for hand washing. The AM cook acknowledged understanding of policies and was able to correctly demonstrate proper use of gloves and hand washing, through demonstration observed by the Food and Beverage Director. On 01/12/12, The Food and Beverage Director conducted individual in-service training with the two servers observed on 12/16/11 to be in the kitchen area without the use of hairnets, regarding the proper use of hairnets, when in the food production areas of the kitchen. Identification of Other Facility Residents that may be affected by the deficient practice With respect to how the facility will identify residents with the potential for the identified concern and take corrective action, the Food and Beverage Director and/or the Assistant Food and Beverage Director will procure food from sources approved or considered satisfactory by Federal, State or local authorities, and store, prepare, distribute and serve food under sanitary conditions. The Food & Beverage Director conducted an all Kitchen staff in-service training on 12/16/11 regarding the proper storage of brooms, proper hand	



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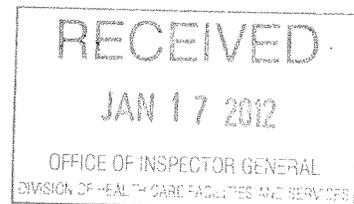
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F 371	<p>Continued From page 5</p> <p>sign posted at the entrances to the kitchen: "Food and Beverage Employees Only, Reminder: Hairnets Required."</p> <p>Observation, on 12/16/11 at 1:15 PM, revealed two (2) staff members working as servers were in the kitchen without required hair coverings. Further observation during the sanitation tour of the kitchen, revealed three (3) brooms were stored in the kitchen area, and were standing with bristles on the floor.</p> <p>Interview, on 12/15/11 at 12:15 PM, with the AM Cook revealed she was trained to change gloves between tasks, and said it was not necessary to wash the hands between each glove change. The AM Cook stated the glove removed from the pants pocket was a dirty glove and that she did not intend to use it, and disposed of it in the trash.</p> <p>Interview, on 12/16/11 at 1:30 PM, with Server #2 revealed he was trained to wear hair covering when in the kitchen.</p> <p>Interview, on 12/16/11 at 1:15 PM, with the Food and Beverage Director and the Certified Dietary Manager revealed they had not read the facility policy for Environment of Care: Storage Spaces which stated brooms should be stored off of the floor.</p> <p>Interview, on 12/16/11 at 2:00 PM, with the Certified Dietary Manager revealed all staff were expected to wash hands after gloves were removed between tasks. The Certified Dietary Manager stated the two (2) staff without hair coverings were working as servers in the dining area and were not required to wear hair coverings</p>	F 371	<p>washing techniques and use of gloves, and hairnet requirement usage within the food production areas within kitchen. The Food and Beverage Director and/or Assistant Food and Beverage Director will meet with all kitchen staff individually to conduct a skills demonstration to ensure proper technique for hand washing and glove usage. Skills demonstration of kitchen staff will be completed by 01/20/11. The Food and Beverage Director and/or Assistant Food and Beverage Director will conduct daily random audits of kitchen staff, for one week, through 01/20/12, to ensure policy is being followed in regards to broom storage, hand washing and glove use, and hair net requirements. The Food and Beverage Director and/or Assistant Food and Beverage Director will then conduct weekly audits for four weeks, and then monthly audits for six months, then quarterly audits to ensure policy is being followed in regards to broom storage, hand washing and glove use, and hair net requirements.</p> <p>Implementation of Systemic Measures With respect to what systemic measures have been put in place to address that stated concern, on 12/16/11, the Food and Beverage Director installed broom storage racks in the storage closet area, to ensure brooms are stored according to company policy, signs were posted in the storage area stating "All brooms must be stored off the floor" according to</p>	



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F 371	Continued From page 6 in a limited area of the kitchen. The Certified Dietary Manager was not aware of the sign at the entrance to the kitchen which prohibited staff from entering the kitchen without hair coverings.	F 371	<p>company policy. The Food & Beverage Director presented all Kitchen staff in-service training, on 12/16/11, regarding the proper storage of brooms, proper hand washing techniques and use of gloves, and hairnet requirement usage within the kitchen area. The Food and Beverage Director and/or Assistant Food and Beverage Director will conduct daily random audits of kitchen staff, for one week, through 01/20/12, to ensure policy is being followed in regards to broom storage, hand washing and glove use, and hair net requirements. The Food and Beverage Director and/or Assistant Food and Beverage Director will then conduct weekly audits for four weeks, and then monthly audits for six months, then quarterly audits to ensure policy is being followed in regards to broom storage, hand washing and glove use, and hair net requirements.</p> <p>Monitoring of Corrective Action With respect to how the plan of corrective measures will be monitored, the Food and Beverage Director and/or the Assistant Food and Beverage Director will provide in-service training upon hire of all new employees and annually regarding the storage of brooms, proper hand washing and glove usage, and hairnet requirements. The Food and Beverage Director and/or Assistant Food and Beverage Director will conduct daily random audits of kitchen staff, for one week, through</p>	



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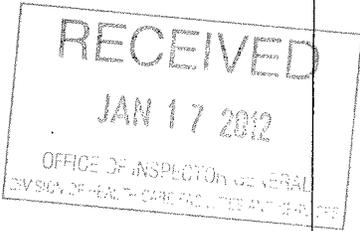
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		F371	01/20/12, to ensure policy is being followed in regards to broom storage, hand washing and glove use, and hair net requirements. The Food and Beverage Director and/or the Assistant Food and Beverage Director will conduct weekly audits for four weeks, and then monthly for six months, then quarterly to ensure policy is being followed. Audits findings will be reported to the Quality Assurance Committee quarterly.	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE <i>X Exe Dia X</i>	(X6) DATE <i>1-13-12</i>
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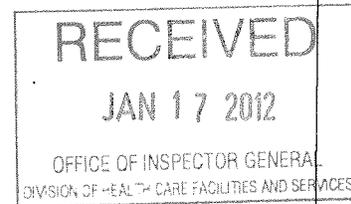
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K 000	<p>INITIAL COMMENTS</p> <p>Amended SOD 01/11/12</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1991</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type III Protected.</p> <p>SMOKE COMPARTMENTS: Four (4) smoke compartments.</p> <p>FIRE BARRIER: The non-certified facility and the Skilled Nursing Facility were separated by a two-hour fire barrier.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors, upgraded in 2001.</p> <p>SPRINKLER SYSTEM: Complete automatic (wet and dry) sprinkler system, upgraded in 2001.</p> <p>GENERATOR: Type II generator. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 12/14/11. The Forum at Brookside was found not in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for forty (40)</p>	K 000		
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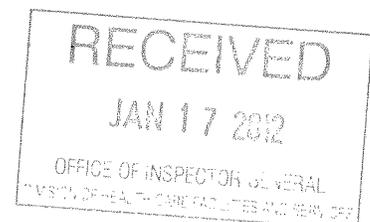
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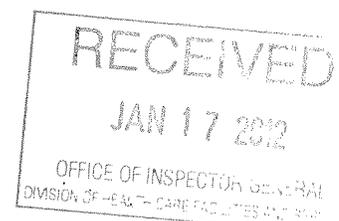
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 beds and the census was thirty-six (36) on the day of the survey. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire) Deficiencies were cited with the highest deficiency identified at F level. NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain doors within a required means of egress, according to NFPA standards. The deficiency had the potential to affect one (1) of the four (4) smoke compartments, staff and visitors. The facility is licensed for forty (40) beds and the census was thirty-six (36) on the day of the survey. The findings include: Observation, on 12/14/11 at 9:45 AM, with the Director of Plant Operations revealed an unapproved lock (slide bolt type) was installed on the egress side of the door to the restroom behind the Nurse ' s Station. Interview, on 12/14/11 at 9:45 AM, with the Director of Plant Operations revealed the slide	K 000	K130 NFPA 101 Miscellaneous Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with federal and state law. Corrective Action for Residents Cited by Deficient Practice With respect to the residents cited, there were no specific residents cited. Identification of Other Facility Residents that may be affected by the deficient practice With respect to how the facility will identify residents with the potential for the identified concern and take corrective action, on 12/14/11, the Director of Plant Operations assessed all facility doors to ensure appropriate locks were in use that do not require a tool or key from egress side of door. Implementation of Systemic Measures With respect to what systemic measures have been put in place to address that stated concern, on 12/14/11, the Director of Plant Operations removed the slide bolt lock from the staff/visitor restroom and on 12/21/11 installed an approved lock that does not require a tool or key from egress side of door.	01/20/12
K 130 SS=D		K 130		



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

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K 130	Continued From page 2 bolt lock could be a deterrent to exiting the restroom in the event of an emergency. Reference: NFPA 101 (2000 Edition) 19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side.	K 130	Monitoring of Corrective Action With respect to how the plan of corrective measures will be monitored, the Director of Plant Operations will perform monthly inspections of the resident/visitor bathroom door, for three months to ensure appropriate locks are in use that do not require a tool or key from egress side of door. Audit findings will be reported to the Quality Assurance Committee quarterly.	
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained according to NFPA standards. The deficiency had the potential to affect each of the four (4) smoke compartments, residents, staff, and visitors. The facility is licensed for forty (40) beds and the census was thirty-six (36) on the day of the survey. The findings include: Observations, on 12/14/11 between 8:30 AM and 10:15 AM, with the Director of Plant Operations revealed: 1. In resident room 34, a refrigerator was plugged into a power strip.	K 147	K147 NFPA 101 Life Safety Code Standard Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with federal and state law. Corrective Action for Residents Cited by Deficient Practice With respect to the residents cited, the Director of Plant Operations on 12/14/11, removed all misused power strips in resident rooms 1, 14, 16, 19, 26, 32, 33, 34 and activity office. Identification of Other Facility Residents that may be affected by the deficient practice	01/20/12



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K 147	<p>Continued From page 3</p> <ol style="list-style-type: none"> 2. In resident room 33, a refrigerator was plugged into a power strip 3. In resident room 32, medical equipment was plugged into a power strip 4. In resident room 26, medical equipment was plugged into a power strip. 5. In the Activities office, a refrigerator was plugged into a power strip. 6. In resident room 14, medical equipment was plugged into a power strip 7. In resident room 16, medical equipment was plugged into a power strip. 8. In resident room 19, medical equipment was plugged into a power strip. 9. In resident room 1, medical equipment was plugged into a power strip. <p>Interviews, on 12/14/11 between 8:30 AM and 10:15 AM, with the Director of Plant Operations revealed he was unaware of the misuse of power strips within the facility.</p> <p>Reference: NFPA 99 (1999 edition)</p> <p>3-3.2.1.2 D</p> <p>Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.</p>	K 147	<p>With respect to how the facility will identify residents with the potential for the identified concern and take corrective action, on 12/14/11, the Director Plant Operations inspected all resident rooms, offices, and common areas to ensure proper usage of all electrical and medical equipment and power strips and removed all misused power strips.</p> <p>Implementation of Systemic Measures With respect to what systemic measures have been put in place to address that stated concern, maintenance staff will perform monthly electrical inspections of resident rooms, offices, and common areas to include removal of unapproved extension cords, multiple outlet adapters and that proper use of power strips are in place. On 12/15/11, Director of Plant Operations conducted training with all maintenance staff relating to proper usage of all electrical and medical equipment and power strips.</p> <p>Monitoring of Corrective Action With respect to how the plan of corrective measures will be monitored, the Director of Plant Operations will review the monthly electrical inspections and conduct random inspections of resident rooms, offices, and common areas, to ensure proper usage of all electrical and medical equipment and power strips. Audit findings will be reported to the Quality Assurance Committee quarterly.</p>		

