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	345426	A. BUILDING _____ B. WING _____	06/12/2014

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VALLEY VIEW CARE & REHAB CENTER	551 KENT STREET ANDREWS, NC 28901

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F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and record reviews, the facility failed to assess residents for the frequency of baths/showers they preferred each week and failed to honor specific food preferences for 2 of 3 residents reviewed for choices. (Resident #6 and Resident #75). The findings included: 1. Resident #6 was admitted on 03/31/14 with diagnosis including cerebral palsy, schizoaffective disorder, mental retardation, major depressive affective disorder and high blood pressure. Resident #6's admission Minimum Data Set (MDS) dated 04/09/14 assessed her as having moderately impaired cognition and the ability to make herself understood. The MDS further assessed Resident #6 as needing extensive assistance with bed mobility, transfer, dressing and hygiene. Resident #6's most recent care plan dated 04/09/14 indicated she required assistance with activities of daily living (ADL's). During an interview on 06/11/14 at 11:59 AM	F 242	1. Resident #6 was not injured related to this citation. Resident # 6 was interviewed by the Licensed Nurse on 6/16/2014 to determine her bath/shower preference as well as frequency. Resident #6 care plan and kardex were updated to reflect resident stated preference. Resident #75 was not injured related to this citation. Resident # 75 was interviewed by the Food Service Director on 6/13/2014 to learn food preferences. Resident # 75 care plan and meal tray card were updated to reflect resident preferences. 2. All residents have the potential to be affected by this citation. The interdisciplinary team asked residents and/or their responsible party about the type and frequency of shower/bath they prefer. Then the residents' care plan and kardex were updated. On 6/13/2014-6/20/2014, the interdisciplinary team asked residents and/or responsible party about the residents' food preferences. Then the	7/9/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 07/04/2014

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F 242	Continued From page 1 Resident #6 revealed she would prefer to have 3 baths/showers a week instead of the 2 baths/showers a week offered by the facility. During an interview on 06/11/14 at 12:11 PM, NA #3 revealed Resident #6 was assigned to get 2 baths/showers weekly on Monday and Thursday. NA #3 further stated each resident received 2 baths/showers a week based on the shower schedule. The shower schedule is divided by hall and room number. NA#3 also explained she understood when to give the showers because she was on the shower team and by looking at the residents Kardex. NA#3 stated if residents asked for additional baths/showers they would try to accommodate them. During an interview on 06/11/14 at 3:04 PM, Nurse#7 revealed residents get 2 baths/showers a week and if a resident requested more than 2 baths/showers a week they would be accommodated. This nurse did not know who assessed the residents for there preference on frequency of baths/showers per week. During an interview on 06/11/14 at 3:14 PM, MDS Coordinator revealed every resident gets 2 baths/showers a week. Some residents requested additional baths/showers and they were accommodated. The MDS Coordinator further stated she did not assess for preference on frequency of baths/showers per week but the activity director did. During an interview on 06/11/14 at 3:24 PM, Activity Director revealed she assessed how important choosing between a bed bath, tub bath, or shower was for a resident. The Activity Director further revealed she did not assess for	F 242	residents' care plans and meal tray cards were updated. New admissions to facility will be asked their preference for bath/shower by day, frequency, and time by Admissions Coordinator and/or Nursing Supervisor. The Food Service Director will interview new admissions for food preferences. 3. Licensed Nurses and Certified Nursing Assistants, were in-serviced by the Director of Clinical Services and/or Nursing Supervisor between the dates of 6/13/2014-6/20/2014. The facility must inquire about each resident's preferences for the frequency and type of bath/showers for each week, and this information must be transcribed to the resident's care plan and kardex accordingly. On 6/12/2014, the Food Service Director was in-serviced by the Corporate Regional Dietician regarding obtaining residents' preferences and updating the care plans and meal tray cards. Quality Improvement monitoring of 10 residents' bathing preferences will be conducted 3 times a week for 2 months, 2 times a week for 2 months, and then 1 time a week for 2 months and/or until substantial compliance is obtained. The Food Service Director will perform Quality Improvement Monitoring of 10 residents' food preferences 3 times a week for 1 month, 2 times a week for 3 months, and then 1 time a week for 2 months and/or until substantial compliance is obtained.	

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F 242	Continued From page 2 preference on frequency of baths/showers per week but the social worker did. During an interview on 06/11/14 at 3:46 PM, Social Worker revealed she assessed when residents would like a bath/shower to be given. Residents were given the preference between morning or evening. The Social Worker further revealed she did not assess for preference on frequency of baths/showers per week. During an interview on 06/11/14 at 5:09 PM with the Director of Nursing (DON) revealed residents get offered 2 baths/showers a week. The DON further stated there was not a system in place for assessing residents' preference for frequency of bathing/showering. 2. Resident #75 was admitted to the facility 02/11/14 with diagnoses which included diabetes, depression, anxiety and peptic ulcer disease. Physician orders on admission included a regular diet with fruit for dessert which remained in effect through the time of the survey. The 05/10/14 Minimum Data Set assessment noted Resident #75 was cognitively intact. Review of the care plan and dietary notes for Resident #75 (since admission) revealed no documentation related to food preferences. During observations of the lunch meal on 06/09/14 at 12:30 PM Resident #75 reported he	F 242	4. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee for 6 months and/or until substantial compliance is obtained. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Assistant Director of Nursing, Medical Director, Social Services, Activities Director, Maintenance Director, and Minimum Data Assessment Nurse.	

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did not like the carrots that were served as part of a mixed vegetable blend and had repeatedly communicated this dislike. Resident #75 stated he told the nursing assistants that served his meal to him in his room that he did not like carrots and also wrote the dislike for carrots on the paper tray card that came with the meal. Resident #75 stated he did not recall anyone ever talking to him since admission about food preferences. Resident #75 stated carrots were served often, especially in mixed vegetables.

In a follow-up interview on 06/11/14 at 5:00 PM Resident #75 stated that in addition to the carrots he did not like cream of wheat, oatmeal or grits. Resident #75 stated he had shared the dislike of all hot cereal with the nursing assistants that delivered meal trays to him in his room. Resident #75 stated he was not aware of who else to share the food dislikes with and, because of stomach issues, he could not tolerate carrots, grits, oatmeal or cream of wheat. Resident #75 stated that every time he is served carrots he tells the nursing assistants he doesn't like them; noting, he had received them on the lunch meal earlier that day. Review of the facility menus noted carrots had been served as part of a mixed vegetable blend for lunch on 06/11/14.

On 06/11/14 at 5:15 PM the Food Service Director (FSD) looked at the facility electronic record and noted she did not have any food dislikes recorded for Resident #75. The FSD stated because of this, Resident #75 would receive all food items on the preplanned menu including carrots, cream of wheat, oatmeal and grits. The FSD stated she was dependent on staff to contact her if a resident reported any food preferences and she did not recall anyone ever

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F 242	Continued From page 4 telling her about any dislikes for Resident #75. At the time of the interview the FSD was informed of the dislikes of Resident #75 which included carrots, cream of wheat, grits and oatmeal. On 06/12/14 at 10:35 AM Resident #75 reported he received a bowl of oatmeal with his breakfast tray that morning. On 06/12/14 at 12:00 PM the facility corporate dietitian reviewed the electronic tray card system and reported there were no dislikes entered for Resident #75. The corporate dietitian reported oatmeal was part of the preplanned menu and because there were no designated dislikes in the electronic system it had been served for breakfast to Resident #75. The FSD was present at the time of the interview and could offer no explanation why the dislikes of carrots, cream of wheat, oatmeal and grits had not been entered in the electronic tray card system after they had been reported to her on 06/11/14.	F 242		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to monitor blood pressure and	F 309	1. Resident #79 suffered no injury related to this citation. Resident #79 was	7/9/14

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F 309	Continued From page 5 administer an antihypertensive medication as ordered by the Physician for 1 of 5 sampled residents reviewed for unnecessary medications (Resident # 79). The facility also failed to monitor 2 of 8 sampled residents bowel movements (Resident #31 and Resident #3). The findings included: 1. a. Resident #79 was admitted on 03/19/14 with diagnoses including hypertensive cardiomyopathy and coronary artery disease. Review of a Physician's telephone order dated 04/17/14 revealed instructions to monitor Resident #79's BP (blood pressure) twice a day and to administer Clonidine (medication used to treat high blood pressure) 0.1 mg (milligrams) every 12 hours as needed for BP greater than 150/90. A care plan for self care deficit dated 03/28/14 included an approach dated 04/17/14 to monitor Resident #79's BP twice a day and to administer Clonidine 0.1 mg every 12 hours as needed for BP greater than 150/90. Review of Resident #79's vital signs and weight record from 04/17/14 through 06/11/14 revealed BPs were recorded twice a day from 04/17/14 through 04/23/14. Resident #79's BP was recorded once on 04/24/14, 05/01/14, 05/08/14, 05/22/14, and 05/29/14. An interview was conducted with the Director of Nursing (DON) on 06/11/14 at 3:45 PM after she had reviewed Resident #79's medical record including Medication Administration Records (MARs). The DON confirmed she could not	F 309	assessed by the physician on 06/26/2014 with no new orders. Resident #31 suffered no injury related to this citation. Resident #31 was assessed by the physician on 07/02/2014 with no new orders. Resident #3 suffered no injury related to this citation. Resident #3 was assessed by the physician on 07/02/2014 with no new orders. On 6/12/2014, Nurse #1 was in-serviced by the Director of Clinical Services on following physician orders, notifying the physician of vital signs outside of stated perimeter, and recording vital signs in the medical record. On 6/13/2014Nurse #3 was in-serviced by the Director of Clinical Services on following physician orders, notifying the physician of vital signs outside of stated perimeter, and recording vital signs in the medical record. On 6/16/2014Nurse #4 was in-serviced by the Director of Clinical Services on following physician orders, notifying the physician of vital signs outside of stated perimeter, and recording vital signs in the medical record. On 6/16/2014, Nurse #5 was in-serviced by the Director of Clinical Services on following physician orders, notifying the physician of vital signs outside of stated perimeter, and recording vital signs in the medical record. 2. All residents have the potential to be affected by this citation. On 06/17/14, the Director of Clinical Services and/or Nursing Supervisor	

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F 309	Continued From page 6 locate any additional BP monitoring for Resident #79 other than the BPs documented on the vital signs and weight record. The DON stated she would expect BPs to be monitored as ordered by the Physician and documented on the residents MAR when they were ordered to be monitored daily. A telephone interview was conducted with Nurse #2 (while she was on duty) on 06/11/14 at 8:25 PM. During the interview Nurse #2 reviewed Resident #79's medical record and confirmed she had signed off on the Physician's telephone order for his BP to be monitored twice a day beginning on 04/17/14. Nurse #2 stated she would have placed this order on the acute vital sign sheet to notify the nurse aides. Nurse #2 further stated the acute vital sign sheets were not saved after the vital signs were recorded and as a result she could not explain why Resident #79's BP's were not monitored twice a day after 04/23/14. During a telephone interview on 06/12/14 at 1:49 PM the Physician stated she noticed during one of her visits Resident #79's BP was not being monitored frequently enough and wrote a specific order for BP monitoring twice a day due to his elevated BPs. The Physician further stated she reviewed Resident #79's BPs her last visit but did not notice how frequently they were being monitored. The Physician indicated she had not written an order to discontinue the monitoring of Resident #79's BP twice a day and would expect his BP to be checked per the order written on 04/17/14. b. Resident #79 was admitted on 03/19/14 with diagnoses including hypertensive cardiomyopathy and coronary artery disease.	F 309	monitored residents requiring daily vital signs and residents requiring anti-hypertensive medications. On 6/17/14, the Director of Clinical Services and/or Nursing Supervisor reviewed/audited the bowel records of current residents. 3. On 6/16/2014-6/30/2014, the Director of Clinical Services and/or Nursing Supervisor in-serviced licensed nurses on following physician orders, notifying physician of vital signs outside set perimeters, and recording vital signs in the medical record and/or Care Tracker System. On 6/16/2014-6/30/2014, the Director of Clinical Services and/or Nursing Supervisor in-serviced Certified Nursing Assistants on recording residents' bowel movements in the medical record, using Care Tracker. Utilizing data recorded in the medical record and/or Care Tracker, the Director of Nursing and/or Nursing Supervisor will perform Quality Improvement monitoring of 10 residents receiving anti-hypertensive medications and daily vital signs. The monitoring will occur 3 times a week for 2 months, 2 times a week for 2 months, and then 1 time a week for 2 months and/or until substantial compliance is obtained. The Director of Nursing and/or Nursing Supervisor will perform Quality Improvement monitoring of bowel movements utilizing the No BM Report from Care Tracker 3 times a week for 6 months and/or until substantial compliance is obtained.	

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F 309	Continued From page 7 Review of a Physician's telephone order dated 04/17/14 revealed instructions to monitor Resident #79's BP (blood pressure) twice a day and to administer Clonidine (medication used to treat high blood pressure) 0.1 mg (milligrams) every 12 hours as needed for BP greater than 150/90. A care plan for self care deficit dated 03/28/14 included an approach dated 04/17/14 to monitor Resident #79's BP twice a day and to administer Clonidine 0.1 mg by mouth every 12 hours as needed for BP greater than 150/90. Review of Resident #79's April and May 2014 Medication Administration Records (MARs) revealed documentation for Clonidine 0.1 mg being given as ordered for elevated BP on 04/17/14, 04/19/14, 04/20/14, 04/22/14, 04/24/14, and 04/29/14. Continued review of the 2014 April and May MARs revealed no documentation of as needed Clonidine 0.1 mg administered to Resident #79 on 04/18/14, 04/23/14, or 05/08/14. Review of Resident #79's vital signs and weight record from 04/17/14 through 05/29/14 revealed the following documented BPs were elevated above the parameters specified by the Physician. There were no nurse's notes or documentation on the MAR regarding the elevated BPs. - 04/18/14 during the 7:00 AM to 3:00 PM shift-Nurse #3 documented a BP of 182/107 mmHg (millimeters of mercury) with a recheck completed with a manual BP cuff which obtained a BP reading of 180/88. Resident # 79's BP monitored later on 04/18/14 during the 3:00 to 11:00 PM shift and was documented as 155/87 mmHg.	F 309	4. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee for 6 months and/or until substantial compliance is obtained. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Assistant Director of Nursing, Medical Director, Social Services, Activities Director, Maintenance Director, and Minimum Data Assessment Nurse.	

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- 04/23/14 during the 11:00 PM to 7:00 AM shift- Nurse #4 documented a BP of 189/104 mmHg.
- 05/08/14 during the 3:00 PM to 11:00 PM shift- Nurse #1 documented a BP of 166/91 mmHg.

An interview was conducted with the Director of Nursing (DON) on 06/11/14 at 3:45 PM after she had reviewed Resident #79's medical record including Medication Administration Records (MARs). The DON confirmed she could not locate any additional nurse's notes or documentation to verify Resident #79 had received the as needed Clonidine 0.1 mg on 04/18/14, 04/23/14, or 05/08/14. The DON stated she expected nurses to administer as needed medication as ordered by the Physician and document on the MAR and the back of the MAR or in a nurse's note.

During a telephone interview on 06/11/14 at 8:25 PM Nurse #2 (while she was on duty) confirmed she was the charge nurse on the 3:00 PM to 11:00PM shift on 05/08/14 and documented Resident #79's BP on the vital signs and weight record. Nurse #2 reviewed Resident #79's medical record during the interview and stated she would have notified Nurse #5 who was the nurse for Resident #79's hall that evening. Nurse #2 reviewed Resident #79's May 2014 MAR and stated there was no documentation to verify the as needed Clonidine 0.1 mg had been administered.

A telephone interview was conducted with Nurse #3 on 06/12/14 at 8:23 AM. Nurse #3 stated the nurse aide (NA) would have brought Resident #79's BP to her on 04/18/14 to record in the

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medical record. Nurse #3 stated she would typically have written a nurse's note and informed the hall nurse of the elevated BP but could not recall if she had done so on 04/18/14.

Nurse #5 was interviewed by phone on 06/12/14 at 9:05 AM. Nurse #5 recalled Resident #79 had as needed Clonidine order for elevated BP but did not recall if she had administered this medication for an elevated BP on 05/08/14. Nurse #5 further explained the NAs take the residents vital signs and report the results to the nurse assigned to each hall.

Attempts to contact Nurse #4, who worked on 04/23/14, were not successful.

During a telephone interview on 06/12/14 at 1:49 PM the Physician stated she expected Resident #79 to receive the as needed Clonidine 0.1 mg any time his BP was elevated above 150/90.

2. Review of signed standing orders in the medical record of Resident #31 included the following:
"Milk of Magnesia (or equivalent of) 30 cc (cubic centimeters) orally every day as needed for constipation. If no results from Milk of Magnesia in 8 hours, insert Dulcolax suppository (or equivalent of). If no results from suppository in 8 hours, give Fleets enema. If no results, call physician".

Resident #31 was admitted to the facility 09/24/12 with diagnoses which included Alzheimer's disease. A significant change Minimum Data Set (MDS) assessment dated 05/05/14 was completed due to initiation of Hospice services. This MDS assessed Resident #31 with severe

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cognitive impairment and dependence on staff for transfers and toileting. The 05/05/14 Care Area Assessment (CAA) associated with the MDS included review of the area "Incontinence" due to issues including constipation/impaction. The CAA assessment noted the following:
Incontinence was triggered because Resident #31 was incontinent of bladder and bowel and needs extensive-maximum assist with toileting. Contributing factors included advanced Alzheimer's disease, delirium and confusion with behavioral disturbances. Resident alert and oriented to person only. She has had a recent decline in condition and is now on Hospice caseload. Staff will continue to provide assist routinely/as needed as incontinent episodes occur.

The 05/05/14 care plan for Resident #31 included the following problem areas:
-Bowel and bladder incontinence with an approach to monitor bowel pattern
-Risk for constipation and risk for dehydration with approaches to monitor bowel elimination pattern every shift, monitor for any signs/symptoms of constipation such as abdominal pain, abdominal distention, nausea, etc and report to physician as indicated.

Resident #31 was hospitalized 04/24/14 and readmitted to the facility 04/28/14. On return to the facility and initiation of Hospice, multiple medications (taken by Resident #31 prior to hospitalization 04/24/14) were discontinued; including Miralax and Senna (two laxatives). Resident #31 was not ordered any laxatives on readmission to the facility 04/28/14. Medications on readmission included Dilaudid, six times a day (a narcotic for pain management). The diet

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order on readmission to the facility 04/28/14 was puree with honey thick liquids; which remained in effect at the time of the survey.

Review of the facility electronic bowel records of Resident #31 from 03/13/14-06/11/14 noted the following:
04/30/14-05/05/14-a seven day period with "0" recorded for bowels for all three shifts
05/23/14-06/04/14-a thirteen day period with "0" recorded for bowels for all three shifts
06/05/14-06/11/14-a six day period with "0" recorded for bowels for all three shifts

Review of the 2014 April, May and June Medication Administration Records (MARs) noted the only medication given for constipation was one dose of 30 cc of Milk of Magnesia on 05/26/14 and 06/11/14. Review of Resident #31s nurses notes and hospice notes since readmission to the facility 04/24/14 did not address administration of Milk of Magnesia, Dulcolax or Fleets enema or any issues with impaction.

On 06/12/14 at 10:15 AM Nurse #1 stated she typically pulled the "no bowel movement" report on her shift to show which residents had gone greater than 72 hours without a bowel movement. Nurse #1 stated she was familiar with Resident #31 and routinely worked with her. Nurse #1 verified Resident #31 was taking laxatives prior to hospitalization 04/24/14-04/28/14 and stated she had noticed a change with her bowel movements since her return to the facility. Nurse #1 stated there had been times she had given Milk of Magnesia to residents and had forgotten to chart it but could not recall any specifics regarding Resident #31. Nurse #1 stated nurses are

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supposed to implement standing orders for residents that had not had a bowel movement in three days. Although she could not recall any specifics related to Resident #31, Nurse #1 stated there had been times she identified residents had a bowel movement (after talking with nursing assistants) and it wasn't recorded in the electronic system. Nurse #1 stated she did administer Milk of Magnesia to Resident #31 on 06/11/14 with good results. Nurse #1 could offer no explanation for the extended times recorded in the facility record that Resident #31 had gone without a bowel movement.

On 06/11/14 at 12:00 PM the Director of Nursing (DON) reported nurses were responsible to generate a report at the start of every shift from electronic charting to determine any residents that had gone greater than three days without a bowel movement. The DON stated the expectation was that standing orders would be implemented and recorded on the MAR for any residents that had gone three days without a bowel movement. The DON stated any issues with bowel movements should be reported to the oncoming shift in report so appropriate follow-up could be made. The DON stated there was not a management system in place to monitor bowel movements for residents with the expectation that nursing staff would be addressing any concerns. The DON stated she was not aware Resident #31 had gone extended times without a bowel movement. The DON stated if the Milk of Magnesia had been administered (as on 05/26/14) and if it was not effective then a Dulcolax suppository should have been given.

3. Review of signed standing orders in the medical record of Resident #3 included the

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following:
"Milk of Magnesia (or equivalent of) 30 cc (cubic centimeters) orally every day as needed for constipation. If no results from Milk of Magnesia in 8 hours, insert Dulcolax suppository (or equivalent of). If no results from suppository in 8 hours, give Fleets enema. If no results, call physician".

Resident #3 was admitted to the facility 03/23/06 with diagnoses including T1-T6 spinal fracture and chronic pain. The quarterly Minimum Data Set (MDS) dated 03/24/14 assessed Resident #3 as dependent on staff for toileting.

The 05/27/14 care plan for Resident #3 included the following problem area:
-Urinary elimination altered with an approach to monitor bowel pattern.

Review of physician orders in the medical record of Resident #3 noted she had been taking Miralax and Senna (two laxatives) on a daily basis for several years.

Review of the facility electronic bowel records of Resident #3 from 03/13/14-06/11/14 noted the following:
03/22/14-03/25/14-a four day period with "0" recorded for bowels for all three shifts
04/09/14-04/13/14-a five day period with "0" recorded for bowels for all three shifts
05/04/14-05/12/14-a nine day period with "0" recorded for bowels for all three shifts
05/17/14-05/24/14-a nine day period with "0" recorded for bowels for all three shifts
05/31/14-06/07/14-an eight day period with "0" recorded for bowels for all three shifts

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Review of the 2014 March, April, May and June Medication Administration Records (MARs) for Resident #3 noted the only medication given for constipation was one dose of 30 cc of Milk of Magnesia on 03/18/14, 04/21/14, 05/09/14 and 06/09/14 and a Dulcolax suppository on 04/13/14.

On 06/12/14 at 10:15 AM Nurse #1 stated she typically pulled the "no bowel movement" report on her shift to show which residents had gone greater than 72 hours without a bowel movement. Nurse #1 stated she was familiar with Resident #3 and routinely worked with her. Nurse #1 stated Resident #3 stayed in bed the majority of the time, was incontinent and dependent on staff to change incontinent briefs. Nurse #1 stated there had been times she had given Milk of Magnesia to residents and had forgotten to chart it but could not recall any specifics regarding Resident #3. Nurse #1 stated nurses are supposed to implement standing orders for residents that had not had a bowel movement in three days. Although she could not recall any specifics related to Resident #3, Nurse #1 stated there had been times she identified residents had a bowel movement (after talking with nursing assistants) and it wasn't recorded in the electronic system. Nurse #1 could offer no explanation for the extended times recorded in the facility record that Resident #3 had gone without a bowel movement.

On 06/11/14 at 12:00 PM the Director of Nursing (DON) reported nurses were responsible to generate a report at the start of every shift from electronic charting to determine any residents that had gone greater than three days without a bowel movement. The DON stated the expectation was that standing orders would be

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F 309	Continued From page 15 implemented and recorded on the MAR for any residents that had gone an extended time without a bowel movement. The DON stated any issues with bowel movements should be reported to the oncoming shift in report so appropriate follow-up could be made. The DON stated there was not a management system in place to monitor bowel movements for residents with the expectation that nursing staff would be addressing any concerns. The DON stated she was not aware Resident #3 had gone extended times without a bowel movement. The DON stated if the Milk of Magnesia had been administered (as on 05/09/14) and if it was not effective then a Dulcolax suppository should have been given.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to provide correct perineal care for a resident who was incontinent and dependent on staff for 1 of 2 residents observed for incontinence care (Resident #87). The findings included: Resident #87 was admitted to the facility on 11/29/13 with diagnoses which included diabetes mellitus, hypertension and dementia. Resident	F 312	1. Resident #87 was not injured related to this citation. On 6/12/2014, Certified Nursing Assistant #1 was in-serviced by the Director of Clinical Services regarding providing proper peri care and notifying the Licensed Nurse when a dressing becomes soiled. On 6/12/2014, Certified Nursing Assistant #2 was in-serviced by the Director of Clinical Services regarding providing	7/9/14

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F 312	Continued From page 16 #87's most recent Quarterly Minimum Data Set (MDS) dated 03/08/14 assessed her as having severe cognitive impairment. The MDS further assessed Resident #87 as needing limited assistance of 2 staff for toileting and personal hygiene. The MDS indicated she was occasionally incontinent of bladder and always continent of bowel. An observation of incontinence care was made on 06/11/14 at 12:08 PM. Nursing Assistants (NA) #1 and #2 provided the care for Resident #87. Resident #87 was lying on her right side in bed when NA #1 checked her for incontinence. Resident #87 was observed to be dependent on staff for care. She was wearing fleece jogging pants which were wet across the back and a brown circled ring was present on the bed sheets. When NA #1 removed the jogging pants, there was liquid, yellow stool on the inside of the pants and on the bottom of Resident #87's shirt. The incontinence brief was saturated with yellow, liquid fecal matter. NA #1 requested assistance with providing incontinence care to Resident #87 because the resident was resistive to being changed. NA #2 entered the room with 2 wet hand towels. NA #1 and NA #2 removed the soiled shirt from Resident #87 and the soiled linen from underneath her. NA #2 washed Resident #87's buttocks and anal area washing front to back. NA #2 then placed a clean sheet on the bed and placed an incontinence brief under Resident #87. NA #1 and NA #2 then rolled Resident #87 onto her back, pulled the front of the brief up and started to fasten the brief. When asked by the surveyor to check Resident #87's front perineal area, NA #2, pulled the front of the brief down and washed Resident #87's front perineal area using disposable washcloths. NA #2	F 312	proper peri care and notifying the Licensed Nurse when a dressing becomes soiled. 2. All residents have the potential to be affected by this citation. Director of Clinical Services and/or Nursing Supervisor observed 12 Certified Nurse Assistants on 6/12/14. On 06/13/2014 through 06/30/2014, the Director of Clinical Services and/or Nursing Supervisor in-serviced Certified Nursing Assistants on proper peri care. 3. The Director of Nursing and/or Nursing Supervisor will perform Quality Improvement monitoring of 2 Certified Nurse Assistant providing peri care each shift 5 times a week for 1 month, 3 times a week for 1 month, 2 times a week for 2 month and 1 time a week for 2 months and/or until substantial compliance is obtained. 4. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee for 6 months and/or until substantial compliance is obtained. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Assistant Director of Nursing, Medical Director, Social Services, Activities Director, Maintenance Director, and Minimum Data Assessment Nurse.	

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F 312	Continued From page 17 used 3 washcloths, wiping from front to back. Fecal matter was observed on the washcloths each time. NA #1 and NA #2 then placed an incontinence brief on Resident #87. When asked if they had checked the dressing on Resident #87's coccyx, NA #1 and NA#2 loosened the incontinence brief and checked the dressing which was loose on one edge and soiled with fecal matter. NA # 1 then notified the wound nurse that the dressing needed changed. An interview was conducted with NA #2 on 06/11/14 at 12:24 PM. When asked how she was expected to clean residents who were incontinent of bowel, she stated she should clean the front and back perineal area washing from front to back. When asked about not washing Resident #87's front perineal area until requested by surveyor, NA #2 stated she got in a hurry because the resident was upset and she forgot to wash her front perineal area. When asked what she was expected to do when a dressing was loose or soiled with fecal matter, she stated she should notify the nurse. An interview on 06/11/14 at 5:32 PM was conducted with the Director of Nursing (DON). The DON stated she expected nurse aides to wash the resident's front and back perineal area and to wash from front to back, using multiple wipes as needed to remove fecal matter. The DON further stated she expected staff to notify the wound nurse or charge nurse if a dressing was loose or soiled with fecal matter.	F 312		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from	F 329		7/9/14

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F 329	Continued From page 18 unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to monitor residents for adverse reactions (tardive dyskinesia) for 3 of 3 sampled residents who were prescribed antipsychotic medications (Resident #70, #55, and #78). The findings included: 1. Resident #70 was admitted on 04/17/14 with diagnoses including vascular dementia and psychosis. The admission Minimum Data Set (MDS) dated 04/24/14 revealed Resident #70 had	F 329	1. Resident #70 suffered no injury related to this citation. Resident #70 was assessed by the physician on 07/02/2014 with no new orders. An Abnormal Involuntary Movement Scale was performed on resident by the Director of Clinical Services on 6/16/2014. Resident # 55 suffered no injury related to this citation. An Abnormal Involuntary Movement Scale was performed on resident by the Director of Clinical Services on 6/16/2014.	

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F 329	Continued From page 19 severely impaired cognition and received an antipsychotic medication since her admission to the facility. The Care Area Assessment (AA) Summary for psychotropic drug use dated 04/24/14 stated Resident #70 received a routine antipsychotic medication due to a diagnoses of psychosis. The AA summary noted the nurses would continue to administer medication as ordered and monitor for side effects and effectiveness of medication and update the Physician as indicated. A care plan dated 04/24/14 stated Resident #70 had the potential for side effects from psychotropic medication use. Interventions included to evaluate the effectiveness and side effects of medications for possible decrease or elimination of psychotropic drugs. Review of Resident #70's June 2014 Physician's orders revealed an order dated 04/17/14 for Resident #70 to receive Trilafon (antipsychotic medication) 2 mg (milligrams) by mouth twice daily and Trilafon 2 mg every six hours as needed for psychosis/aggression. Continued review of Resident #70's medical record revealed no AIMS (Abnormal Involuntary Movement Scale) had not been completed since admission. The AIMS assessment is used to detect tardive dyskinesia which is a common adverse side effect of antipsychotic medications. An interview was conducted with the Director of Nursing (DON) on 06/11/14 at 3:45 PM. During the interview the DON stated she expected AIMS assessments to be completed on admission and then every six months for any resident who was	F 329	Resident #78 suffered no injury related to this citation. Resident #78 was assessed by the physician on 06/19/2014 with no new orders. An Abnormal Involuntary Movement Scale was performed on resident by the Director of Clinical Services on 6/16/2014. Nurse#6 was in-serviced by the Director of Clinical Services on 6/17/2014 on completion of Abnormal Involuntary Movement Scale upon admission and quarterly. 2. Residents receiving anti-psychotic medication have the potential to be affected by this citation. On 06/16/2014, the Director of Clinical Services completed an audit of current residents receiving anti-psychotic medications for Abnormal Involuntary Movement Scale. The Director of Clinical Services and/or Nursing Supervisor in-serviced licensed nurses, on 06/16/2014 through 06/30/2014, regarding completion of Abnormal Involuntary Movement Scale on residents with anti-psychotic medications upon admission and quarterly. On admission and quarterly, residents will have an Abnormal Involuntary Movement Scale assessment completed by the Director of Clinical Services or Nursing Supervisor. 3. The Director of Nursing and/or Nursing Supervisor will perform Quality Improvement monitoring of 10 residents for completion of Abnormal Involuntary Movement Scale on admission and	

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F 329	Continued From page 20 prescribed an antipsychotic medication. The DON further stated the MDS nurse completed the AIMS assessments until approximately six months ago when Nurse #6 assumed responsibility for the assessments. The DON reviewed Resident #70's medical record and could not locate an AIMS assessment. A telephone interview with Nurse #6 on 06/12/14 at 3:15 PM revealed she did not recall completing an AIMS assessment for Resident #70 and suggested it may have been completed by the nurse who admitted her on 04/17/14. 2. Resident #55 was admitted on 10/25/13 with diagnoses including bipolar disorder. The admission Minimum Data Set dated 10/25/13 revealed Resident #55 received an antipsychotic medication 7 days during the 7 day look back period. The Care Area Assessment Summary for behavioral symptoms dated 10/25/13 revealed Resident #55 was admitted from the hospital with diagnoses including dementia with agitation and received antipsychotic medications. A care plan dated 10/25/13 noted Resident #55 had episodes of yelling with interventions including administering behavior medications as ordered by the Physician. Review of Resident #55's May 2014 Physician's orders revealed an order dated 01/06/14 for Resident #55 to receive Seroquel (atypical antipsychotic medication used for the treatment of bipolar disorder) 50 mg (milligrams) twice daily and 200 mg at bedtime.	F 329	quarterly assessments three times a week for 2 months, two times a week for 2 months, 1 time a week for two months and/or until substantial compliance is obtained. 4. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee for 6 months and/or until substantial compliance is obtained. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Assistant Director of Nursing, Medical Director, Social Services, Activities Director, Maintenance Director, and Minimum Data Assessment Nurse.	

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Continued review of the medical record revealed Resident #55's last AIMS assessment was completed on 10/25/13.

An interview was conducted with the Director of Nursing (DON) on 06/11/14 at 3:45 PM. During the interview the DON stated she expected AIMS assessments to be completed on admission and then every six months for any resident who was prescribed an antipsychotic medication. The DON further stated the MDS nurse completed the AIMS assessments until approximately six months ago when Nurse #6 assumed responsibility for the assessments. The DON reviewed Resident #55's medical record and could not locate an AIMS assessment completed since 10/25/13. The DON confirmed an AIMS assessment should have been completed in April 2014.

A telephone interview with Nurse #6 on 06/12/14 at 3:15 PM revealed she thought she had completed Resident #55's AIMS assessment with her last MDS assessment (05/30/14) and would have placed it in the medical record.

3. Resident #78 was admitted on 03/07/14 with diagnosis which included mental disorder not otherwise specified (NOS) and abnormal involuntary movements. The most recent Minimum Data Set (MDS) dated 04/03/14 revealed Resident #78 was cognitively intact and received an antipsychotic medication 7 days during the 7 day look back period.

The Care Area Assessment (CAA) Summary for psychotropic drug use dated 04/03/14 stated

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Resident #78 received routine antipsychotic medications due to diagnosis for depression, anxiety, and insomnia. The CAA noted nursing would continue to administer medications as ordered and monitor for side effects/effectiveness and update the Physician as indicated. The CAA note further stated psychiatric consults would be made as indicated and Resident #78 would continue on hospice caseload for metastatic cancer.

A care plan dated 04/03/14 stated Resident #78 had potential for side effects from psychotropic medication use. The care plan goals were to have no evidence of side effects from psychotropic medication through next review. Interventions included evaluate effectiveness and monitor side effects of medication for possible decrease/elimination of psychotropic medications.

A review of Resident #78's Physician's orders revealed an order for Resident #78 to receive Seroquel 50mg (milligrams) by mouth every evening for depressive disorder, anxiety disorder, and recurring depression.

Continued review of Resident #78's medical record revealed no AIMS (Abnormal Involuntary Movement Scale) assessment had been completed since admission. The AIMS assessment is used to detect tardive dyskinesia which is a common adverse side effect of antipsychotic medications.

An interview was conducted with the Director of Nursing (DON) on 06/11/14 at 3:45 PM. During the interview the DON stated she expected AIMS assessments to be completed on admission and then every six months for any resident who was

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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
F 329	Continued From page 23 prescribed an antipsychotic medication. The DON reviewed Resident #78's medical record and could not locate an AIMS assessment.	F 329		
F 371 SS=E	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 observations and staff interview the facility failed to clean beverage dispensing nozzles and discard expired food. The findings included: During the initial tour of the facility on 06/09/14 from 11:45 AM-12:30 PM the following concerns were identified: 1. The interior of two spray nozzles used to dispense multiple beverages was observed. A significant amount of cream colored build-up was observed inside the nozzles which came in contact with any beverages dispensed. 2. A five pound container of low fat cottage cheese was stored ready for use in the walk in refrigerator. The manufacturer expiration date	F 371	1. No residents were injured related to this citation. The two spray nozzles used to dispense beverages were cleaned by the Food Service Director on 6/9/2014. The out of date Cottage cheese and chocolate milk were discarded on 6/9/2014 by the Food Service Director. The Food Service Director was in-serviced on 06/12/14 by the Executive Director regarding cleaning the spay nozzles and discarding expired foods. 2. All residents have the potential to be affected by this citation. On 6/9/2014, an audit of all food was completed by the Food Service Director, checking for expiration dates. On 6/13/14, the Food Service Director in-serviced the Dietary Aides and cooks,	7/9/14

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	345426	A. BUILDING _____ B. WING _____	06/12/2014

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F 371	Continued From page 24 stamped on the container was 05/18/14. Approximately 1/4 of the cottage cheese remained inside the container. 3. Nine, single serve containers of chocolate milk with a manufacturer expiration date of 06/08/14 were stored ready for use. Seven of these cartons were in the milk box cooler and one on shelving in the walk in refrigerator. One carton was inside a cooler stored on a "snack cart" in the nourishment pantry. On 06/09/14 at 1:00 PM the Food Service Director (FSD) observed the above concerns. The FSD removed the nozzles from the beverage dispensing units. The FSD reported the nozzles should be removed and soaked/cleaned twice a week. The interior of one of the nozzles had a formed cream colored gelatinous matter measuring approximately 1" X 1/4" which was removed intact by the FSD. The interior of the other nozzle had a thick cream colored buildup which encompassed the entire perimeter. The FSD checked the kitchen cleaning schedule and noted cleaning the beverage dispensing nozzles had been inadvertently left off the cleaning schedule. The FSD stated she didn't know when the dispensing nozzles had last been removed and cleaned. The FSD could not explain why the milk and cottage cheese had not been removed from service and noted all staff were responsible for removing any food past the expiration date.	F 371	on cleaning daily the spray nozzles used to dispense beverages and check daily the expiration dates of foods and discard foods that have reached expiration. 3. The Executive Director and/or Food Service Manager will conduct Quality Improvement Monitoring of the spray nozzles used to dispense beverages 5 times a week for 1 month, 3 times a week for 2 months, 2 times a week for 1 month, and then 1 time a week for 1 month and/or until substantial compliance is obtained. The Executive Director and/or Food Service Manager will conduct Quality Improvement Monitoring of food expiration dates 5 times a week for 1 month, 3 times a week for 2 months, and then 2 times a week for 1 month then 1 time a week for 1 month and/or until substantial compliance is obtained. Any identified items out of date will be discarded by the Executive director and/or Food Service Manager. 4. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee for 6 months and/or until substantial compliance is obtained. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Assistant Director of Nursing, Medical Director, Social Services, Activities Director, Maintenance Director, and Minimum Data Assessment Nurse.	

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F 441	Continued From page 25	F 441		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		7/9/14

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F 441	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on observations during incontinence care, staff failed to use proper infection control practices including hand washing, glove usage and handling of soiled linens to prevent cross contamination and soiling of environmental surfaces during 1 of 4 observations of care. The findings included: An observation of incontinence care was made on 06/11/14 at 12:08 PM. Nursing Assistants (NA) #1 and #2 provided the care for Resident #87. Resident #87 was lying on her right side in bed when NA #1 checked her for incontinence. Resident #87 was observed to be dependent on staff for care. She was wearing fleece jogging pants which were wet across the back and a brown circled ring was present on the bed sheets. When NA #1 removed the jogging pants, there was liquid, yellow stool on the inside of the pants and on the bottom of Resident #87's shirt. The incontinence brief was saturated with yellow, liquid fecal matter. NA #1 placed the soiled jogging pants on the floor at the foot of Resident #87's bed. NA #1 requested assistance with providing incontinence care to Resident #87 because the resident was resistive to being changed. NA #2 entered the room with 2 wet hand towels. NA #1 and NA #2 removed the soiled shirt from Resident #87 and the soiled linen from underneath her and NA #1 placed it on the floor with the jogging pants. NA #2 washed Resident #87's buttocks and anal area washing front to back. Without changing the gloves, which had been in contact with fecal matter, NA #2 then	F 441	1. Resident #87 suffered no harm from this citation. Resident #87 was assessed by the physician on 06/19/2014 no new orders. Certified Nursing Assistant#1 was in-serviced by the Director of Clinical Services on 6/11/2014 regarding hand washing, proper glove usage, and proper handling of linens. Certified Nursing Assistant#2 was in-serviced by the Director of Clinical Services on 6/11/2014 regarding hand washing, proper glove usage, and proper handling of linens. 2. All current residents have the potential to be affected by this citation. The Director of Clinical Services and/or Nursing Supervisor completed observations of hand washing, proper glove usage, and linen handling 06/16/2014 through 06/20/2014. 3. The Director of Clinical Services and/or Nursing Supervisor in-serviced Certified Nursing Assistants and Licensed Nurses on infection control practices for hand washing, proper glove usage, and linen handling on 06/16/2014 through 06/30/2014. The Director of Nursing and/or Nursing Supervisor will perform Quality Improvement monitoring of 2 Certified Nurse Assistants for proper hand washing, usage of gloves, and handling of	

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F 441	Continued From page 27 placed a clean sheet on the bed and placed an incontinence brief under Resident #87. NA #1 and NA #2 then rolled Resident #87 onto her back, pulled the front of the brief up and started to fasten the brief. When asked by the surveyor to check Resident #87's front perineal area, NA #2 pulled the front of the brief down and washed Resident #87's front perineal area using disposable washcloths. She used 3 washcloths, wiping from front to back, and fecal matter was observed on the washcloths each time. Without changing gloves or washing their hands, NA #1 and NA #2 then placed an incontinence brief on Resident #87. When asked if they had checked the dressing on Resident #87's coccyx, NA #1 and NA#2 loosened the incontinence brief and checked the dressing which was loose on one edge and soiled with fecal matter. NA # 1 then notified the wound nurse that the dressing needed changed. When the nurse was finished changing Resident #87's dressing, NA #1 removed the soiled clothes and linen from the floor of Resident #87's room. A yellow circular stain approximately 6 inches in diameter, which was the same color of the fecal matter, was visible on the floor where the soiled clothes had been. On 06/11/14 at 12:45 PM observation of the floor of Resident #87's room revealed the 6 inch yellow stain remained unchanged. An interview was conducted with NA #2 on 06/11/14 at 12:24 PM. When asked what she was trained to do with handwashing and glove usage when providing incontinence care, she stated she should have changed her gloves and washed her hands after removing the soiled clothing and brief and washing the resident before she placed a	F 441	linen each shift 5 times a week for 1 month, 3 times a week for 1 month, 2 times a week for 2 month, and 1 time a week for 2 months and/or until substantial compliance is obtained. 4. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee for 6 months and/or until substantial compliance is obtained. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Assistant Director of Nursing, Medical Director, Social Services, Activities Director, Maintenance Director, and Minimum Data Assessment Nurse.	

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F 441	Continued From page 28	F 441		

clean brief on the resident. NA #2 stated she should have washed Resident #87's front perineal area before being asked to do so by the surveyor. NA #2 stated she got in a hurry because the resident was upset and she forgot to wash her front perineal area or change her gloves and wash her hands. When asked what she was expected to do when a dressing was loose or soiled with fecal matter, she stated she should notify the nurse.

An interview was conducted with NA #1 on 06/11/14 at 12:35 PM. NA #1 stated she should not have placed the soiled clothing and linen in the floor but she didn't have a bag in her pocket.

An interview on 06/11/14 at 12:55 PM with NA #1 in Resident #87's room confirmed the yellow stain was from the liquid fecal matter that was on the clothes and linens that had been placed in the floor. NA #1 stated I should have called housekeeping to clean it up.

An interview on 06/11/14 at 5:32 PM was conducted with the Director of Nursing (DON). The DON stated she expected nurse aides to wash the resident's front and back perineal area and to wash from front to back, using multiple wipes as needed to remove fecal matter. The DON further stated she expected staff to notify the wound nurse or charge nurse if a dressing was loose or soiled with fecal matter. The DON stated she expected soiled linens to be placed in a bag and not be in direct contact with the floor. The DON further stated she expected staff to change gloves and wash their hands after removing soiled clothing and providing incontinence care before placing a clean brief on the resident. The DON stated she expected the

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F 441	Continued From page 29 NAs to notify the wound nurse or charge nurse about loose or soiled dressings. When asked what staff were expected to do when there was visible contamination of environmental surfaces with fecal matter, she stated staff should clean up as much as they could and notify housekeeping staff to disinfect the area.	F 441		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by:	F 520		7/9/14

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F 520	Continued From page 30 Based on records reviews and staff interviews the facility's Quality Assurance process failed to monitor if effective systems were in place regarding resident bowel movements. The findings included: An interview was conducted with the Administrator on 06/12/14 at 5:50 PM. During the interview the Administrator stated the facility's Quality Assessment and Assurance (QA) committee met on a monthly basis and included herself, the Medical Director, the Director of Nursing, all department heads. There were no QA monitoring tools regarding maintaining an effective monitoring practice. The Administrator stated the monitoring for regular bowel movement was missed.	F 520	1. No residents were injured related to this citation. 2. An audit of resident bowel movements was completed by the Director of Clinical Services and/or Nursing Supervisor on 6/20/2014. 3. The Interdisciplinary team was re-educated on F520 and the Facilitys Policy and Procedure for Quality Assurance Performance Improvement by the Regional Director of Clinical Services on 6/24/2014. The Director of Nursing and/or Nursing Supervisor will perform Quality Improvement monitoring of bowel movements utilizing the No BM Report from Care Tracker 3 times a week for 6 months and/or until substantial compliance is obtained. 4. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee for 6 months and/or until substantial compliance is obtained. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Assistant Director of Nursing, Medical Director, Social Services, Activities Director, Maintenance Director, and Minimum Data Assessment Nurse.	