STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345319	A. BUILDING _____ B. WING _____	C 05/07/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELDERBERRY HEALTH CARE	415 ELDERBERRY LANE MARSHALL, NC 28753

(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 No deficiencies were cited as a result of the complaint investigation Event ID #II8D11.	F 000		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272		5/19/15

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

Electronically Signed | 06/01/2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews, the facility failed to accurately complete comprehensive care assessments for 3 of 9 residents reviewed for comprehensive Minimum Data Set assessments. (Residents #16, #28, and #22).
The findings included:
1. Resident # 16 was admitted to the facility 02/24/15 with diagnoses which included aspiration syndrome, history of stroke, and vascular dementia. An admission Minimum Data Set (MDS) dated 03/08/15 indicated Resident #16's cognition was moderately impaired. The MDS specified Resident #16 required extensive assistance of 1 person for eating and other activities of daily living. The MDS further specified the resident complained of difficulty with swallowing and was on a mechanically altered diet.

A Nutrition Care Area Assessment (CAA) associated with the admission MDS assessment included pneumonia as one of Resident #16's diagnoses. The CAA did not specify the pneumonia was associated with aspiration. The CAA further specified the resident was on a pureed diet with nectar thick liquids, needed assist with meals, and his weight was 218.6 pounds. "Will not proceed to care plan" was the last sentence documented in the CAA. The CAA did not identify risks of weight loss or aspiration

F272
It is the policy and normal practice of this facility to conduct initially and periodically, a comprehensive, accurate, standardized and reproducible assessment of each resident¿s functional capacity and to accurately assess the comprehensive needs of each resident.
Affected Residents:
¿ Resident #16¿s nutrition Care Area Assessment (CAA) and plan of care was reviewed and revised by the Care Plan Coordinator on 5/08/2015 to identify weight loss and aspiration as potential risks.
¿ Resident #28¿s nutrition CAA and plan of care was reviewed and revised by the Director of Nursing (DoN) on 5/08/2015 to include the failure to thrive diagnosis, to identify weight loss as a potential risk and to include the comfort measures which resident was receiving.
¿ Resident #22 discharged on 01/27/15. Resident #22 was a closed record review. Update to the CAA is not applicable.
¿ Beginning 5/08/15, clinical staff was made aware by Care Plan Coordinator of CAA and/or care plan changes for Resident #16 and #28.
Other Residents:
¿ Beginning 05/08/15, CAAs of all other

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F 272	Continued From page 2 for Resident #16. Medical record review revealed a note written by the Registered Dietician dated 03/11/15. The note specified Resident #16 lost 3.4 pounds in 2 weeks prior to the date this note was written. An interview was conducted with the MDS Coordinator and Director of Nursing (DON) on 05/07/15 at 3:43 PM. The MDS Coordinator stated the CAA worksheet identified Resident #16 was on a mechanically altered diet and had swallowing problems. The MDS Coordinator explained a CAA should be the basis for the care plan so the Interdisciplinary Team could determine the underlying causes and risk factors related to a specific resident. The MDS Coordinator explained verbally Resident #16 had a history of aspiration pneumonia. He added to develop the CAA, he looked at triggers on the CAA worksheet and pulled data from the chart, hospital records, family, and resident if the resident was interviewable. The MDS Coordinator stated a care plan was developed for this resident on 04/06/15 related to Resident #16's unstable weight and being referred to Restorative Dining. The DON acknowledged the lack of risk factors and unstated problems of actual weight loss related to Resident #16's nutrition issues were not contained in the nutrition CAA of 03/08/15. 2. Resident #28 was admitted to the facility 08/22/14 with diagnoses which included failure to thrive, chronic debility, and congestive heart failure. Review of Resident #28's medical record	F 272	residents were reviewed by the DoN and Assistant Director of Nursing (ADoN) to ensure accurate completion. Systemic Changes: ¿ The DoN reviewed with the MDS Coordinator the RAI manual to ensure nutrition CAAs include potential nutrition risks. Emphasis was placed on potential risks (potential for weight loss, potential for aspiration, failure to thrive, comfort measures, etc.). ¿ Care plans will continue to be reviewed and updated by the Care Plan Team at weekly scheduled clinical meetings. ¿ Orders and progress notes will continue to be reviewed in the weekly clinical meeting by the Care Plan Team. CAAs and care plans will continue to be updated when appropriate. Quality Assurance: ¿ MDS Coordinator is enrolled in a refresher MDS workshop. ¿ The DoN and/or designee will audit the care plans of all new admissions on a weekly basis to ensure pertinent CAAs and care plans are in place. In addition, care plans will be systematically audited during the weekly clinical meetings to ensure they are up to date and appropriate. This will continue on an ongoing basis. ¿ Results of the audits will be reported monthly to the Quality Assurance Committee for the next 3 months and quarterly thereafter. Any instances of noncompliance will be analyzed to determine when they occurred; how they occurred and why they occurred and	

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F 272	Continued From page 3 revealed a physician's progress note dated 02/09/15. In the note, the physician wrote Resident #28 desired comfort measures only. Additional review of Resident #28's medical record revealed a note dated 02/11/15 written by the Registered Dietician (RD). The note specified the resident lost 5.8% body weight in the last month. The RD further specified 60 centimeters (cc) of a dietary supplement was to be administered to Resident #28 three times a day. The note also included the resident's weight needed to be monitored closely. A significant change Minimum Data Set (MDS) dated 03/19/15 indicated Resident #28's cognition was severely impaired. The MDS specified Resident #28 did not speak, rarely understood others, and required extensive assistance of 1 person for eating. The MDS further specified the resident experienced coughing or choking during meals or when swallowing medications and was on a mechanically altered diet. A Nutrition Care Area Assessment (CAA) associated with this significant change MDS included heart related diagnoses but did not mention failure to thrive. The CAA identified Resident #28 with unclear speech. Additional CAA review revealed the resident was on a puree diet with honey thick liquids and was working with the Speech Therapist due to choking and coughing during meals. The CAA further specified Resident #28 needed extensive assistance with eating and positioning. CAA documentation included will proceed to care plan. The CAA did not identify Resident #28 as at risk for weight loss or was on comfort measures. The CAA did not include the resident was on 60cc of a	F 272	responsive action will be taken including further action.	

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dietary supplement to help prevent weight loss and if the resident accepted the supplement when it was offered.

An interview with the RD was conducted on 05/06/15 at 10:55 AM. The RD stated Resident #28 did have a diagnosis of failure to thrive and was on comfort measures. She stated she had implemented measures in an attempt to get the resident to eat. The RD explained residents on comfort measures were at high risk for weight loss.

An interview was conducted with the MDS Coordinator and Director of Nursing (DON) on 05/07/15 at 3:43 PM. The MDS Coordinator pointed out the CAA worksheet identified Resident #28 was on a mechanically altered diet. The MDS Coordinator explained a CAA should be the basis for the care plan so the Interdisciplinary Team could determine the underlying causes and risk factors related to a specific resident. He added to develop the CAA, he looked at triggers on the CAA worksheet and pulled data from the chart, hospital records, family, and resident if the resident was interviewable. The DON acknowledged risk factors and unstated problems related to failure to thrive diagnosis and nutritional supplements implemented for Resident #28 were not contained in the nutrition CAA of 03/10/15.

3. Resident #22 was admitted to the facility 12/26/14 with diagnoses which included left hip

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fracture, and pneumonia. An admission Minimum Data Set (MDS) dated 01/07/15 indicated Resident #22 was cognitively intact. The MDS specified Resident #22 required assistance of 1 person for eating and extensive assistance for mobility activities of daily living. The MDS further specified the resident experienced difficulty with swallowing and was on a mechanically altered diet.
A Nutrition Care Area Assessment (CAA) associated with the admission MDS assessment included weight loss as one of Resident #22's diagnoses. The CAA further specified the resident was on a mechanical soft diet and her weight was 97.4 pounds. "Will proceed to care plan" was the last sentence documented in the CAA. The CAA did not identify risks of weight loss including swallowing difficulty for Resident #22.

Medical record review of nutrition assessment dated 12/26/14 revealed Resident #22's height 5'0" and weight 103.4 lbs. Boost/Ensure three times per day and ProSource 30 cc two times per day were added to Resident #22's mechanical soft diet.

An interview was conducted with the MDS Coordinator and Director of Nursing (DON) on 05/07/15 at 4:00 PM. The MDS Coordinator stated the CAA worksheet identified Resident #22 was on a mechanically altered diet and had swallowing problems. The MDS Coordinator explained a CAA should be the basis for the care plan so the Interdisciplinary Team could determine the underlying causes and risk factors related to a specific resident. The MDS Coordinator explained in order to develop the CAA, he looked at triggers on the CAA worksheet

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F 272	Continued From page 6 and pulled data from the chart, hospital records, family, and resident if the resident was interviewable. The MDS Coordinator stated a care plan was developed for this resident on 01/07/15 related to Resident #22's unstable weight and being referred to Restorative Dining. The DON acknowledged the lack of risk factors and unstated problems included swallowing difficulty and provision of nutritional supplements related to Resident #22's nutrition issues were not contained in the nutrition CAA of 01/07/15.	F 272		
F 309 SS=D	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 and resident interviews, the facility failed to implement the facility bowel protocol for no bowel movement greater than 3 days for 2 of 5 residents reviewed for providing care and services to maintain wellbeing. (Residents #73 and #78). The findings included: 1. A review of facility Physician's Standing Orders dated 12/18/14 included the following instructions for constipation: If no bowel movement (BM) in 3 days auscultate (listen to	F 309	F309 It is the policy and normal practice of this facility to ensure that each resident receives and the facility provides 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. Affected Residents: ¿ On 05/07/15 Resident #73 and #78 were reassessed for recent bowel movements, bowels were auscultated.	5/19/15

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F 309	Continued From page 7 lower abdomen with a stethoscope) for bowel sounds. If present in all 4 quadrants of the abdomen and the resident was without pain give milk of magnesia 15 milliliters (ml) by mouth or biscodyl 5 milligrams (mg) 2 tablets one time or biscodyl 10 mg per rectum (PR) one time. If no BM in 4 days give fleets enema PR. If fleets ineffective, administer soap suds enema. The Physician's Standing Orders specified the definition of constipation was no significant BM for 2 to 3 days. The Standing Orders were effective for up to 7 days. If the symptoms persist confirmation orders to extend beyond the 7 days must be obtained from the physician. If severe pain was present the physician must be called to rule out obstruction. Resident #73 was admitted to the facility on 11/18/14 with diagnoses including Alzheimer's dementia with psychosis and history of cerebral vascular accident. The most recent Minimum Data Set (MDS) dated 02/18/15 indicated Resident #73 was severely cognitively impaired and required extensive assistance of 2 persons for most activities of daily living (ADL). She was coded as always incontinent of bowel and bladder. Record review of a care plan for Resident #73, dated 12/04/14 and reviewed 03/05/15, revealed a problem of dementia and incontinence of bowel and bladder. One approach included: Monitor bowel movements (BM) and signs and symptoms of constipation. (No BM in 3 days report to nurse or doctor). Review of Physician orders for the month of March for Resident #73 revealed the following medications that could cause constipation such as Tylenol 325 milligrams (mg) tab 2 tab by mouth twice a day and Ultram 50 mg 1 tab by mouth every 4 hours as needed for pain.	F 309	Each resident had a recent BM. No intervention was needed. Other Residents: ¿ The DoN and ADoN on 5/08/15 reviewed residents not sampled and their current medical records to determine if those residents received bowel care in accordance to facility bowel protocol. No other residents were affected. Systemic Changes: ¿ An in-service was provided by pharmacy educational nurse on 5/14/15 with licensed clinical staff regarding monitoring bowel records and the importance of ensuring bowel protocol is followed if needed. ¿ An additional bowel monitoring step has been included. Electronic Health Record (EHR) BM record(s) will be reviewed by the day shift charge nurse and where appropriate follow-up with nurses assigned to each hall to ensure protocol is followed. Quality Assurance: ¿ The DoN and/or designee will audit BM records 3 times a week to ensure when needed protocol is being followed. In addition, records will continue to be systematically audited during the various weekly interdisciplinary meetings to ensure they are up to date and appropriate. This will be done on an ongoing weekly basis. ¿ Results of the audit will be reported monthly to the Quality Assurance Committee by the DoN or designee. Any instances of noncompliance will be analyzed to determine when such noncompliance occurred, why and how.	

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F 309	Continued From page 8 A review of Resident #73's bowel elimination record revealed no bowel movement documented on any shift from 03/16/15 through 03/21/15. A review of Resident #73's Medication Administration Record (MAR) for the month of March, 2015 revealed no medication or laxative related to bowel evacuation was administered from 03/16/15 through 03/21/15. On 05/07/15 at 9:29 AM an interview was conducted with Nurse Aide (NA) #2 who had provided care for Resident #73 and other residents on her hall. NA # 2 stated bowel movements were recorded on the facility computer system. The NA said she charted the bowel movements on the computer and the nurse on the hall checked the printed computer sheets. She explained if it had been 3 days since a resident had a bowel movement the nurse gave the sheet to the nurse aide to monitor for a BM. The NA revealed if a resident still did not have a BM the nurse will make a call for a laxative. The NA stated she was not able to ask Resident #73 if she had a BM because of the resident ' s dementia. The NA said she had not been aware Resident #73 had not had a bowel movement within 3 days because she had not received a computer printout from the nurse to let her know Resident #73 needed to be monitored to make sure she had a bowel movement within 3 days. On 05/07/15 at 9:51 AM an interview was conducted with Nurse # 4 who had provided care for Resident #73. She stated she checked residents for bowel patterns and constipation. She said she checked the computer for a report that provided the residents ' bowel patterns in the last 3 days and how many bowel movements residents had including the size of the bowel movements. She stated if a resident had not had a bowel movement in 3 days it triggered a bowel	F 309	Appropriate responses will be initiated.	

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warning (have not had a bowel movement in 3 days). The nurse revealed the facility had standing orders for constipation for 3 days. The nurse stated the standing orders required nurses to check for bowel sounds and assess the resident. The nurse said the bowel sounds get documented on the Medication Administration Record (MAR) and should show the resident had bowel sounds in all 4 quadrants. The nurse revealed if the resident did not have bowel sounds in all 4 quadrants the resident could have a blockage. The nurse said if a resident had a blockage the physician would be called for new orders. The nurse revealed she was not able to ask Resident #73 about her bowel movements because of her dementia. The nurse said she had not assessed Resident #73 for bowel movements on 03/16/15 through 03/21/15 and the bowel protocol had not been followed.
On 05/07/15 at 12:20 PM an interview was conducted with the Director of Nursing (DON). She stated documentation for scheduled toileting for Resident #73 showed a bowel movement on 03/11/15 and 03/15/15. The DON reviewed Resident #73 ' s bowel elimination record and stated her expectation was if Resident #73 had a warning nursing staff should have investigated and asked nurse aides if Resident #73 had a bowel movement and if not proceed with standing orders.
On 05/07/15 at 12:30 PM an interview was conducted with the Medical Director (MD). The MD stated if residents did not have a bowel movement in 3 days, the bowel protocol should be followed.

2. Resident #78 was admitted to the facility on 9/10/2013 with diagnoses including diabetes,

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acute on chronic respiratory failure, and acute on chronic renal failure.
A quarterly Minimum Data Set (MDS) dated 4/2/15 indicated Resident #78's cognition was intact. The MDS indicated the resident required limited to extensive assistance with dressing, toileting, and bathing. The MDS also specified limited range of motion and resident being continent of bowel and bladder.
A review of Resident #78's medical record from 3/05/15 to 5/05/15, revealed resident had 4 separate occasions of 4 to 5 days with documentation of no bowel movements. Further review of Resident #78's medical record revealed no documentation of assessments related to bowels from 3/15/15 to 5/5/15.
On 5/06/15 at 12:06 pm Nurse #4 was interviewed about resident assessments for constipation. She stated the process started with assessment of the bowel and bladder report they printed daily. When they determined a resident had more than three days without a bowel movement the bowel protocol was implemented as ordered by the Medical Director (MD). Nurse #4 stated these assessments were completed daily by the nurses. She could not offer any explanation why there was no documentation regarding bowel assessment noted in the medical record.
In an interview conducted with the Nurse #5 on 5/07/15 at 9:54 am, Nurse #5 explained the nurses assessed the resident whenever there was a complaint of constipation or documentation of no bowel movement for more than three days. Nurse #5 stated the Nurse Aides (NAs) recorded bowel and bladder activity for each resident in a computerized tracking system each shift. This history was printed off daily by the nurses to check resident history of bowel movements and

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F 309	Continued From page 11 need for assessment and intervention. Nurse #5 stated she did not know why she did not document an assessment for Resident #78 during the occasions of no recorded bowel movements. On 5/07/15 at 10:24 am Resident #78 was interviewed, she stated she often has gone for more than three days without having had a bowel movement. She also revealed she was able to be on a regular schedule and had a bowel movement every day while at home. Resident #78 could not remember if she had told the nurses or not that she had not had a bowel movement in many days. An interview on 5/07/15 at 10:28 am with the Director of Nursing (DON). She said her expectation of care was for the nurses to document the assessment for constipation on the medication administration record (MAR). She also included that there was a standing bowel protocol for all of the residents ordered by the MD. The DON further stated her expectations were all nurses were to follow this protocol of assessments, documentation, and interventions as necessary for the individual resident. In an interview on 5/07/15 at 12:30pm with the MD, he stated if residents did not have a bowel movement in three days, the bowel protocol should been followed.	F 309		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition	F 322		5/19/15

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	345319	A. BUILDING _____ B. WING _____	C 05/07/2015

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F 322	Continued From page 12 demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to check placement of a gastrostomy tube before administering medication for 1 of 1 resident observed for medication administration via gastrostomy tube. (Resident #12). The findings included: A review of a facility policy dated 2006 regarding nutritional and medication administration via feeding tubes including gastrostomy (G) tubes was reviewed. The procedure specified in part prior to fluid administration check the position of tube by placing a stethoscope over the stomach and instill a small amount of air into the feeding tube. Listen for air to enter the stomach. The policy then described how to proceed with nutrition/medication administration. Resident #12 was admitted to the facility 06/08/06 with diagnoses which included Huntington's chorea. A review of Resident #12's medical record	F 322	F322 It is the policy and normal practice of this facility to ensure that a resident who is fed by naso-gastric or gastrostomy tube receives the appropriate treatment and to restore, if possible, normal eating skills. Affected Residents: ¿ Resident #12 was checked on 05/07/15 for tube placement by DoN and nurse #6. ¿ Nurse #6 was retrained by DoN on procedure protocol including checking for tube placement prior to starting a procedure. Other Residents: ¿ No other residents have a feeding tube. Systemic Changes: ¿ Prior to providing feeding tube	

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F 322	Continued From page 13 revealed a physician's order to administer Haldol 2 milligrams per G tube daily at 12:00 PM. An observation was conducted on 05/06/15 at 12:39 PM of Nurse #6 administering Haldol 2 milligrams via G tube to Resident #12. The resident had an abdominal binder in place covering the G tube and holding it in place. The resident was observed with jerking movements in her arms. Nurse #7 was assisting Nurse #6 with the medication administration. Nurse #6 was observed administering water through a 60 centimeter syringe via gravity. She followed the water flush with the medication which was followed by the last flush of water. Nurse #6 did not check placement of the G tube before starting the procedure. An interview with Nurse #6 and Nurse #7 at 12:43 PM on 05/06/15 revealed Nurse #6 should have checked placement of the G tube before administering the water flushes and the medication. Nurse #7 stated it was her normal practice to check G tube placement via auscultation before administering water flushes or medication. Nurse #7 stated she should have reminded Nurse #6 to check for placement since she was the senior nurse. An interview was conducted with the Director of Nursing (DON) on 05/06/15 at 4:24 PM. The DON stated it was her expectation for nurses to check G tube placement via auscultation before medication administration.	F 322	treatment and services, all licensed nurses were quizzed and then observed by DoN or ADoN to ensure demonstration of proper technique for checking for tube placement and procedure protocol. ¿ Tube placement and procedure protocol was added to the new employee orientation checklist for licensed clinical staff. Quality Assurance: ¿ Refresher training is also being provided by Nurse Consultant at next visit to licensed clinical staff regarding tube feeding procedure protocol including checking for placement. ¿ The DoN and/or designee will randomly audit feeding tube technique weekly for the next 2 months to ensure protocol is being followed. ¿ Results of the audit will be reported monthly to the Quality Assurance Committee by the DoN or designee. Any instances of noncompliance will be analyzed to determine when such noncompliance occurred, why and how. Appropriate responses will be initiated.	
F 520 SS=D	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	F 520		6/1/15

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F 520	Continued From page 14 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: Based on record review and staff and resident interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in January of 2014. This was for one recited deficiency which was originally cited in December of 2013 on a recertification survey and on the current recertification survey. The deficiency was in the area of providing care and services to maintain wellbeing. The facility's continued failure during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program.	F 520	F520 It is the policy and practice of the facility to maintain a quality assessment and assurance committee (QAA) consisting of the outlined members that meet monthly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action designed to correct identified quality deficiencies. The facility has policies and procedures designed to maintain these goals. Quality assurance monitoring, physician reviews, consultant reviews, and staff training are examples of	

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F 520	Continued From page 15 The findings included: This tag is cross referred to: F 309: Based on record review and staff and resident interviews, the facility failed to implement facility bowel protocol for no bowel movement greater than 3 days for 2 of 5 residents reviewed for providing care and services to maintain wellbeing. (Residents #73 and #78). During the facility's December 2013 recertification survey, the facility was cited for failure to administer 2 doses of a respiratory medication to a resident reviewed for providing care and services to maintain wellbeing. An interview was conducted with the Administrator and Director of Nursing (DON) on 05/07/15 at 4:54 PM. The DON stated the facility implemented their plan of correction regarding medication administration. She added the facility pharmacist had assisted with monitoring staff with medication administration. The DON stated she reviewed quarterly reports regarding bowel frequency. She expected the nurses and unit managers to monitor the reports daily and follow through. The Administrator concurred.	F 520	the many components utilized. Affected Residents: ¿ On 05/07/15, Resident #73 and #78 bowels were auscultated and were reassessed for recent bowel movements. Each resident had a recent BM. No intervention was needed. ¿ Implemented additional audit of BM records and related assistive medications. See F309. ¿ Facility staff will continue to engage residents, where appropriate, and families; and conduct quality assurance monitoring through audits, physician reviews, various consultant reviews, and ongoing staff training as various methods to correct identified quality measures. Other Residents: ¿ On 5/08/15, the DoN and ADoN reviewed residents not sampled and their current medical records to determine if those residents received bowel care in accordance to facility bowel protocol. No other residents were affected. ¿ Implemented additional audit of BM records and related assistive medications. See F309. ¿ Facility staff will continue to engage residents, where appropriate, and families; and conduct quality assurance monitoring through audits, physician reviews, various consultant reviews, and ongoing staff training as various methods to correct identified quality measures. Systemic Changes: ¿ Additional steps included to the BM record monitoring process. ¿ A review was conducted by the Administrator, DoN, pharmacy education	

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F 520	Continued From page 16	F 520	nurse and of the QAA process of how issues are identified and monitored by the QAA committee. ¿ Reviewed various reporting mechanisms to ensure committee is following guidelines. ¿ Clinical staff re-trained on bowel monitoring and protocol. Quality Assurance: ¿ Reports from QAA audits and studies will be reviewed and acted upon by the QAA committee. ¿ Results of audits related to F309 will be reported monthly to the Quality Assurance Committee by the DoN or designee. Any instances of noncompliance will be analyzed to determine when such noncompliance occurred, why and how. Appropriate responses will be initiated.	