STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24GC	A. BUILDING: _____ B. WING _____	C 04/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOYINGTON HEALTH AND REHABILITATION	1530 BROAD AVE GULFPORT, MS 39501

(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) COMPLETE DATE
M 000	Initial Comments The State Agency conducted an annual recertification along with 5 complaint(s), MS #17682, MS#17673, MS#17647, MS#17635 and MS#17576 from (04/20/21) to (04/23/21). During the survey, the SA determined that the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm. The SA substantiated MS 17576 for leaving residents soiled for extended period of time and cited M 500. The SA did not substantiate MS #17647 for misappropriation, MS #17682 for unqualified personnel and MS #17673 MS for failing to provide appropriate wound care and #17635 for medical records and staffing with no citations related to the complaint. The SA also cited M 655, M 740, and M 815during the survey.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate;	M 500		6/13/21

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M 500	Continued From page 1 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice,	M 500		

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M 500	Continued From page 2 free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;	M 500		

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M 500	Continued From page 3 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by:	M 500		

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M 500	Continued From page 4 Level II Based on observation, interviews, record reviews, and facility policy review the facility failed to provide the residents who were unable to carry out Activities of Daily Living (ADL's) the necessary services to maintain good personal hygiene for four (4) of 103 residents observed. (Resident #17, Resident #101, Resident #16, and Resident #55) Resident #17 Findings Include: Review of the facility's "Abuse, Neglect and Exploitation Policy", dated 11/2019, revealed: It is the policy of this facility to provide protection for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of residential property. The policy also revealed the definition of neglect as "Neglect means the failure of the center, its associates or service providers, to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress". Review of the facility's "Covid-19 Temporary Nurse Aide Skills Competency Checklist" dated 1/20/20 revealed Personal Care Attendant (PCA) #1 was in-serviced on providing Activities of Daily Living (ADL's). Review of the facility's Vulnerable Persons Act dated 01/22/2021 revealed PCA #1 was in-serviced on Abuse and Neglect. Review of the facility's In-service sign in sheet	M 500	This plan of correction constitutes a written allegation of compliance for the deficiencies cited. Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly This Plan of Correction is submitted to meet the requirements established by the State and Federal Law. 1. On April 20, 2021, Residents #17, #16 and #101 were provided incontinent care and Resident #55 was provided a bath on April 23, 2021. Director of Nursing educated Licensed Practical Nurse (LPN)#2 and LPN #4 on rounds, responsibility of nurse overseeing certified nursing assistants (CNA) and staff assignments on April 26, 2021. Director of Nursing educated Personal Care Assistant (PCA)#1 on Incontinent Care and making rounds on April 23, 2021. Director of Nursing educated CNA#6 and CNA#3 on resident showers and residents appearance on April 28, 2021. 2. On April 28, 2021, incontinent residents were observed for incontinent needs and addressed by LPN and Risk Manager Registered Nurse (RN)for any patients identified. 3. Staff Development RN and Risk Manager RN educated staff on Abuse Neglect, Following Resident Care Plan, Elder Justice Act, Incontinent Care and providing showers beginning April 23,	

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M 500	Continued From page 5 dated 3/26/21 revealed PCA #1 was in-serviced on Resident Rights and Abuse and Neglect. Review of the facilities comprehensive care plan Resident #17 has a self-care deficit related to limited mobility, general weakness often declines to change her clothes and often wears same clothes multiple days. Resident #17 is high risk for infection as evidenced by history of urinary tract infection and neurogenic bladder, and high risk for impaired skin integrity related to decreased mobility. During an observation on 04/20/21 at 11:40 AM, revealed Resident # 17 lying on her back in her bed on two reusable incontinent pads with her eyes closed. The incontinent pads Resident # 17 was lying on and the sheets were visibly wet. Resident #17's gown was also saturated in urine. Observation revealed the incontinent pads Resident # 17 was lying on and the sheets had yellow circular stains with brown rings around the edges of the yellow circular stains. Resident # 17's room had a very strong urine odor. During an interview 04/20/21 at 11:40 AM, with Resident # 17 revealed she was confused and displayed difficulty answering questions. Resident #17 confirmed she had urinated and her clothes and linen were wet. Resident # 17 stated "it would be good to be dry". On 04/04/20/21 at 11:43 AM, the State Agency (SA) notified Licensed Practical Nurse (LPN)#2 that Resident # 17 was requesting assistance. LPN #2 went down the hall and spoke to the LPN #4. On 04/20/21 at 12:06 PM, observation of Resident # 17 sitting on the side of the bed	M 500	2021 and ending April 28, 2021. The Local Ombudsman educated facility staff on Residents' Rights, Abuse / Neglect on May 20, 2021. The Facility Administrator educated facility staff on Abuse / Neglect, Incontinent Care and bathing residents on May 20, 2021. On April 28, 2021, incontinent residents were observed for incontinent needs and addressed by Licensed Practical Nurse and Risk Manager, Registered Nurse for patients identified. 4. Director of Nursing, Administrator, Assistant Director of Nursing or Risk Manager will monitor incontinent care for providing timely and showers are provided timely, to include off hours visits weekly times three weeks then monthly times three months and quarterly thereafter. Monitoring began May 5, 2021. Adverse findings will be brought to the monthly Quality Assurance / Performance Improvement Committee by Director of Nursing for continued compliance quarterly. ADHOC Quality Assurance Meeting was held on April 30, 2021.	

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wearing the same clothes with both incontinent pads folded back. Both wet pads and both wet sheets remained on Resident #17's bed.

Observation on 04/20/21 at 12:15 PM, revealed Resident # 17 was sitting on the bed wearing the same clothes with both wet pads and both wet sheets still on the bed. Resident #17's lunch tray was set up in front of her. Resident #17 was eating lunch. The smell of urine continued to be very strong in Resident # 17's room. The odor was strong enough to be evident in the hallway.

On 04/20/21 at 12:20 PM, an observation revealed Certified Nursing Assistant (CNA) #5 entered Resident # 17's room with linens in a clear plastic bag. CNA #5 closed the door to Resident # 17's room.

On 04/20/21 at 12:25 PM, observation revealed CNA #5 exited Resident # 17's room with the full clear plastic bag. Resident # 17 was sitting on the bed eating lunch wearing the same saturated clothes. The linens on the bed were clean and the bed was clean and neat.

On 04/20/21 at 12:30 PM, during an interview Resident #17 confirmed she was still wearing wet,wearing urine-soaked clothes and saturated disposable brief. When asked if the CNA had left the same dress on but changed the brief, the resident pushed the lunch tray aside, stood up, pulled her dress up and stated "No she didn't" revealing a disposable brief which sagged down between Resident # 17's thighs almost to the resident's knees. The brief was saturated with urine.

On 04/20/21 at 12:40 PM, an observation revealed LPN #4 entered Resident # 17's room

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and removed the lunch tray while Resident # 17 sat on the bed wearing the wet dress and saturated brief. The strong odor of urine remained in the room.

On 04/21/21 at 02:47 PM, an observation of Resident #17 sitting on the side of the bed. Resident #17's brief and gown was saturated in urine. The urine had a strong odor. Resident #17 had three pink incontinent pads with dark brown stains.

During an interview on 04/21/21 at 02:47PM, with Resident #17 confirmed her brief was saturated in urine. Resident #17 said she does normally call the staff when she needs assistance. Resident#17 said the staff will stick their head in the room sooner or later. Resident #17 said "I know I stink but it's ok." Resident #17 said I do not get around like I used too. Resident #17 confirmed her incontinent pads had not been changed for several hours. Resident #17 said she did not want to bother the staff.

During an observation on 04/22/21 at 05:35 AM, with PCA #1 revealed Resident #17 lying in bed. Resident #17's gown and pink incontinent pad was saturated in brown urine. Resident #17 removed her brief and threw it in the garbage can. The room had a strong urine odor.

During an interview on 04/22/21 at 05:45PM, with PCA #1 confirmed Resident #17's pad was saturated with urine and dried brown stains. PCA #1 said the resident is a heavy wetter. PCA #1 said the resident took herself to the bathroom and removed her brief sometimes during the night. PCA #1 said she did not know the resident had removed her brief and laid down on the saturated pads.

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M 500	Continued From page 8 During an interview on 04/22/21 at 10:24 AM, with LPN #2 revealed she made the CNA assignments for the 11-7 shift CNA's/PCA's. LPN #2 said PCA #1 was assigned to the front of the hall. LPN #2 said she worked on that hall earlier that night on the medication cart. she thought PCA #1 was making rounds. LPN #2 said another nurse came in at 11:00 PM. LPN #2 went to the 200 hall until 1:00 AM. LPN #2 said it is her responsibility to make sure the PCA's and CNA's provide ADL care to the residents. LPN #2 said she has been on the medication cart for the last three weeks and is unable to monitor the staff. LPN #2 confirmed the residents could develop pressure ulcers, UTI's and other complications for laying in urine for a long period of time. LPN #2 also confirmed the residents' incontinent briefs and incontinent pads should not have brown stains on them. During an interview on 04/22/21 at 11:40 AM, with the Director of Nurses (DON) confirmed the resident's incontinent briefs and pads should not be saturated in brown tea colored urine. The DON said the resident could develop pressure ulcers, UTI's and other complications from laying in urine for several hours. The DON said this is unacceptable and will not be tolerated. The DON said the staff were educated to provide ADL care every 2 hours and as needed. Record review of the Face Sheet revealed the facility admitted Resident #17 on 1/08/18 with the diagnoses that included Major Depressive Disorder, Neuromuscular Dysfunction of bladder and Congestive Heart Failure. The admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/14/21 revealed Resident#17 had a Brief Interview for Mental	M 500		

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M 500	Continued From page 9 Status (BIMS) of 15 that indicated Resident #17 is cognitively intact. Resident #16 Findings Include: Review of the facility's Comprehensive Care Plan revealed Resident #16 has an increased risk for infection as evidenced by recent history of urinary tract infection, high risk for impaired skin integrity related to bowel and bladder incontinence and limited mobility. Resident #16 is also at risk for incontinence of bowel and bladder related to confusion, dementia, and impaired mobility. During an Observation with PCA#1 on 04/22/21 at 05:37 AM, revealed Resident #16 was lying in bed with a saturated tea colored brief and incontinent pad. The room had a strong urine odor. In an Interview with PCA #1 04/22/21 at 05:38 AM, confirmed the brief and pad was saturated in urine with dried brown stains on the brief and pads. PCA #1 said the resident is a heavy wetter. The PCA said Resident #16 was changed 2 hours ago. In an interview on 04/22/21 at 10:24 AM, with LPN #2 revealed she made the CNA assignments for the 11-7 shift CNA's/PCA's. LPN #2 said the PCA #1 was assigned to the front of the hall. LPN #2 said she worked on that hall earlier that night on the medication cart.She thought the PCA was checking on the residents. LPN #2 said it is her responsibility to make sure the PCA's and CNA's provide ADL care to the residents. LPN #2 said she has been on the medication cart for the last three weeks and is unable to monitor the staff.	M 500		

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M 500	Continued From page 10 LPN #2 confirmed the residents could develop pressure ulcers, UTI's and other complications for laying in urine for a long period of time. LPN #2 also confirmed the residents' incontinent briefs and incontinent pads should not have brown stains on them. Record review of the Face Sheet revealed the facility admitted Resident #16 on 1/29/2010 with diagnoses that included Mixed incontinence, Benign prostatic hyperplasia, and Dementia. The admission MDS with an (ARD) of 01/14/21, revealed Resident#16 had a BIMS score of 6 which indicated Resident #16 is cognitively impaired. Resident #101 Review of the facility's comprehensive care plan revealed Resident #101 has increased risk for infection as evidenced by recent history of Pseudomonal urinary tract infection, benign Prostatic Hyperplasia with lower urinary tract symptoms, Urinary Retention and Impaired skin integrity related to bowel and bladder incontinence. On 04/22/21 at 05:40 AM,an observation revealed Resident #101 lying in bed with head of the bed elevated. Resident #101 was non- verbal and confused and unable to make needs known. PCA #1 and SA observed Resident #101 lying in bed with a saturated brief. The brief and incontinent pads were saturated with tea colored urine and brown stains. In an interview on 04/22/21 at 05:41 AM, with PCA #1 said Resident #101 is a heavy wetter. PCA #1 said she tries to get to them as soon as	M 500		

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M 500	Continued From page 11 she can. PCA #1 said the resident hit her in the mouth a few days ago so she did not provide care for him. "That's on me, I'll take that one." During an interview on 04/22/21 at 05:46 AM, with Resident #101's roomate (Resident #85) confirmed the staff did not come in the room during the night to provide ADL care. Residents #85's last quarterly MDS dated 3/17/21, revealed a BIMS score of 15 indicating Resident #85 is cognitively intact. Resident #85 reported Resident #101 does not get ADL care often. Resident #85 stated Resident # 101 is unable to make his needs known. Resident #85 said he calls the staff often to clean Resident #101 and to assist with his meals. Resident #85 is the Resident council President for this facility. In an interview on 04/22/21 at 10:24 AM,during an interview with the LPN#2 revealed she made the CNA assignments for the 11-7 shift CNA's/PCA's. The UM said the PCA #1 assigned to the front of the hall. LPN #2 said she worked on the 100 hall earlier that night on the medication cart. she thought the PCA's were making rounds. LPN#2 said another nurse came in at 11:00 PM. LPN#2 went to the 200 hall until 1:00 AM. LPN#2 said it is her responsibility to make sure the PCA's and CNA's provide ADL care to the residents. LPN #2 said she has been on the medication cart for the last three weeks and is unable to monitor the staff. LPN#2 confirmed the residents could develop pressure ulcers, UTI's and other complications for laying in urine for a long period of time. LPN#2 also confirmed the residents' incontinent briefs and incontinent pads should not have brown stains on them. During an interview on 04/22/21 at 11:40 AM, the DON confirmed the resident's incontinent briefs	M 500		

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M 500	Continued From page 12	M 500		

and pads should not be saturated in brown tea colored urine. The DON said the residents could develop pressure ulcers, UTI's and other complications from lying in urine for several hours. The DON also said this is unacceptable and will not be tolerated. The DON said the staff were educated to provide ADL care every 2hrs and as needed.

Record review of the Face Sheet revealed the facility admitted Resident #101 on 4/25/17, with diagnoses that included Pseudomonal Urinary Tract Infection, Benign Prostatic Hyperplasia with lower urinary tract symptoms, Urinary Retention, and Impaired Skin Integrity. The admission MDS with an ARD of 3/25/19 revealed Resident#101 had a BIMS of 3 indicating Resident #101 is cognitively impaired.

Resident #55

A record review of the MDS with ARD dated 2/25/21 section G revealed resident requires extensive assistance with ADL's.

A record review of Resident #55's Admission Record revealed diagnoses of Contracture right hip and Abnormal posture.

On 4/23/21 at 10:00 AM, in an interview and observation with Resident # 55 revealed Resident #55 initially stated that staff had not given him a bath in 2 months. Resident #55 then stated that he had a bed bath last week by a night time CNA.

A record review of the resident bath schedule

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24GC	A. BUILDING: _____ B. WING _____	C 04/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOYINGTON HEALTH AND REHABILITATION	1530 BROAD AVE GULFPORT, MS 39501

(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) COMPLETE DATE
M 500	Continued From page 13 revealed resident should get a bath on Monday, Wednesday and Friday. A record review of residents bath task shows resident did not get a bath in the last 7 days. On 04/23/21 02:14 PM, in an interview with Resident # 55 stated he did not get a bath before going to the hospital for surgery on 4/22/21. On 04/23/21 02:40 PM, in an interview with CNA #2, stated that she helped CNA #6 get resident ready to go to the hospital. She stated she did not give resident bath that she help change resident brief and dress resident. She denied knowing if CNA#6 gave a bath to Resident #55. On 04/23/21 02:48 PM, the SA phoned CNA#6 and did not get an answer. The SA was unable to leave a message. On 4/23/21 at 3:07 PM, in an interview with LPN #2 stated the the nurses are supposed to check behind the CNA's and sign off behind the CNA's. She stated CNA#6 was supposed to give Resident # 55 a bath Wednesday morning. She looked at the sheet and confirmed there was no documentation of Resident #55 receiving a bath. She stated the nurses are responsible for checking behind the CNA's. On 4/23/21 at 3:10 PM, in an interview with CNA#6 stated that she did not give Resident #55 a shower or bed bath. She stated Resident #55 refused a shower. She stated she just wiped his bottom, face and under the arms. She stated she did not document in the computer because she got locked out of the system and was unable to chart. She stated she tried to notify the the nurse but was unable to.	M 500		

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	24GC	A. BUILDING: _____ B. WING _____	C 04/23/2021

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M 500	Continued From page 14 On04/23/21 04:10 PM, in an interview with the DON stated residents should get a bath. He stated it is very important for residents to get a bath. He stated it can cause skin breakdown or infection. He stated CNA #6 did not come to him about being locked out of the system to chart.	M 500		
M 740	45.26 SOCIAL SERVICES AND RESIDENT ACTIVITIES SOCIAL SERVICES AND RESIDENT ACTIVITIES This Statute is not met as evidenced by: Level II Based on staff interviews, record review, and facility policy review, the facility failed to employ a Licensed/Qualified Social Worker for four (4) days of four (4) days of survey. Findings include: Review of the facility's, "Social Services" policy, dated 11/2001 revealed, "The Director of Social Services is a qualified social worker." During an interview with the Social Services Director on 4/22/21 at 2:30 PM, the State Agency (SA) asked for a copy of her social worker qualifications/license. The Social Services Director stated she will provide a copy to the SA. During an interview with the Administrator on 4/22/21 at 3:00 PM to discuss qualifications and license of Social Worker, the Administrator advised SA the previous social worker had been terminated and the facility has recently made a job offer to an applicant who declined the job.	M 740	1. A qualified social worker was hired on April 28, 2021 and began employment on May 19, 2021. Beginning May 19, 2021 and ending May 25, 2021, Licensed Social Worker made rounds to identify any psychosocial concerns with the residents. This social worker Is a licensed social worker with a Masters Degree in Social Work. Rounds were made to identify psychological issues or concerns with the residents by Risk Manager RN on April 23, 2021. No concerns identified. 2. Rounds were made to identify psychological issues or concerns with the residents by Risk Manager RN on April 23, 2021. No concerns identified. At the time of survey, the social workers had a Bachelors Degree in Social Science and Public Health and a Masters Degree in Healthcare Administration with emphasis on Public Health	6/13/21

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M 740	Continued From page 15 The Administrator stated the Social Services Director has two master's degrees and a copy of the degrees were provided to the SA. The Administrator states the current Social Services Director does not have a degree in Social Work and is not a Licensed Social Work. There is no Licensed Social Worker supervising the current Social Services Director. The facility is licensed for 180 beds and currently has a census of 111 residents.	M 740	3. Administrator received training on April 23, 2021 by Director of Operations to describe the qualifications of a Social Worker for a center 120 beds or more. 4. Administrator will monitor the Social Workers Qualifications beginning May 19, 2021, Administrator will monitor Social Worker's qualifications monthly times three months, then quarterly thereafter. Any adverse findings will be brought to the Quality Assurance / Performance Improvement Committee to ensure continued compliance.	