STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155801		05/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(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 0000 Bldg. 00		F 0000		
	This visit was for the Investigation of Complaint IN00198969, Complaint IN00199528, and Complaint IN00199902. Complaint IN00198969 - Substantiated. Federal/State deficiencies related to the allegations are cited at F282, F309, F353, and F441. Complaint IN00199528 - Substantiated. Federal/State deficiencies related to the allegations are cited at F282 and F353. Complaint IN00199902 - Substantiated. Federal/State deficiencies related to the allegations are cited at F353. Survey dates: May 9, 10, and 11, 2016 Facility number: 000450 Provider number: 155801 AIM number: 100273890 Census bed type:			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	SNF/NF: 50 Total: 50 Census payor type: Medicare: 10 Medicaid: 35 Other: 5 Total: 50 Sample: 15 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed by #02748 on May 12, 2016.			

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F 0282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview, and record review, the facility failed to ensure a medication was given with meals, as prescribed by the physician, for 1 of 3 residents reviewed during a medication pass, in a sample of 15. Resident A Findings include: On 5/9/16 at 9:55 A.M., LPN # 1 was observed administering medications to Resident A. The medications included Ferrous Sulfate. The prescription label on the medication indicated, "Ferrous sulfate tid [three times a day] with meals." LPN # 1 administered the medication to Resident A when she was in the therapy department. No food was given with the medication.	F 0282	By submitting the enclosed material we are not admitting thetruth or accuracy of any specific findings or allegations. We reserve the right to contest the findingsor allegations as part of any proceedings and submit these responses pursuantto our regulatory obligations. Thefacility request the plan of correction be considered our allegation ofcompliance effective 06/10/2016to the state findings of the complaint survey conducted on May 9, 10 and11, 2016. F - 282 *The corrective action taken for those residents found tobe affected by the deficient practice is that* residentidentified as resident A is now receiving their medications with meals asprescribed by the physician. *The corrective actiontaken for the other residents having the potential to be affected by the samedeficient practice is that* a housewide audit of	06/10/2016

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	On 5/9/16 at 11:45 A.M., during an interview with LPN # 1, she indicated she did not administer the medication with food. The clinical record of Resident A was reviewed on 5/9/16 at 2:55 P.M. A Physician's order, initially dated 4/15/16 and on the May 2016 orders, indicated, "Ferrous Sulfate 325 mg Take 1 tablet by mouth (3) times daily (with each meal)." The Medication Administration Record (MAR) indicated the Ferrous Sulfate was to be given three times a day with meals at 8:00 A.M., 12:00 P.M., and 5:00 P.M. On 5/11/16 at 9:30 A.M., the Director of Nursing provided the current facility policy on "Medication Administration," dated 1/27/16. The policy included, "...The licensed nurse and/or QMA shall administer each resident's medications in accordance with the physician's orders and the resident's plan of care...." This Federal tag relates to Complaint IN00198969 and Complaint IN00199528. 3.1-35(g)(2)		all medicationadministration times has been completed and medication administration timesadjusted in accordance with physician's orders and facility practices. All residents are receiving their medicationsin accordance with the physician's orders and the plan of care. *The measures or systematic changes that have been put intoplace to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for alllicensed nurses and QMAs on the facility's policy related to medicationadministration with a focus on ensuring that medications are to be administeredin accordance with the physician's orders and the residents individualized planof care. *The corrective actionwill be monitored to ensure the deficient practice will not recur through thequality assurance program by* the development and implementation of aQuality Assurance tool. This tool willmonitor the administration of medication in accordance with physician's ordersand the resident's plan of care. Thistool will be completed by the Director of Nursing and/or her designee daily forseven days and then weekly for three weeks and then monthly for three monthsand then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's QualityAssurance meeting to determine if any additional action is	

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			warranted.	
F 0309 SS=D Bldg. 00	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.			
	Based on observation, interview, and record review, the facility failed to ensure a resident admitted with a terminal diagnosis had a pain assessment and care plan developed upon admission, had her	F 0309	F – 309 *The corrective action taken for those residents found tobe affected by the deficient practice is that* theresident identified as resident H has had a new pain assessment completed. Their pain medication orders have beenreviewed. The resident is receiving painmedication as needed to control the resident's level of	06/10/2016

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	pain assessed and the effectiveness of pain medication documented, for 1 of 3 residents reviewed for pain control, in a sample of 15. (Resident H) Findings include: On 5/9/16 at 8:50 A.M., the Director of Nursing (DON) indicated Resident H was on hospice, and had a diagnosis of end stage cardiac disease. The DON indicated Resident H was admitted with a pressure ulcer on her coccyx. On 5/9/16 at 8:55 A.M., during an observation of a medication pass, a staff member informed QMA # 1 that Resident H requested a pain pill and a nerve pill. QMA # 1 checked the Medication Administration Record, and indicated "it was too soon" for a pain pill. On 5/10/16 at 9:00 A.M., a skin assessment was requested on Resident H. Resident H indicated, "I need to talk to you. My pain is not being relieved. I can't stand it. I want to go back to the hospital." The DON was notified at that time, and she indicated that she would notify hospice. The clinical record of Resident H was reviewed on 5/10/16 at 10:40 A.M. The		pain. The resident will continue to be assessedrelated to pain control due to their terminal condition and medicationsadjusted based on the resident's pain needs. The care plan has been up-dated to include a plan of care related to theresident's pain issues. *The corrective actiontaken for the other residents having the potential to be affected by the samedeficient practice is that* a housewide audit has been completed on allresident's pain assessments to ensure they are current and accurate. Upon review of the assessments a review ofthe resident's pain medications has been completed to ensure that the currentpain medication orders meet the current pain needs of the resident. In addition a review of the care plans hasbeen completed to ensure a care plan is in place to address the residents' painissues. *The measures or systematic changes that have been put intoplace to ensure that the deficient practice does not recur is that* the facility has reviewed its policy and proceduresrelated to pain management. A mandatoryin-service has been provided for all licensed nurses and QMAs to review thefacility policy and procedure on pain management. *The corrective actionwill be monitored to ensure the deficient practice will not recur through*	

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	resident was admitted to the facility on 5/3/16 with diagnoses including, but not limited to, coronary artery disease and cardiomyopathy. An Admission Assessment, dated 5/3/16 at 1:00 P.M., included: "...Transfers, Total assist - hoyer [mechanical lift], Non-weight bearing, unable to ambulate...Disoriented To: Place, Person...Periods of confusion, poor short term memory...." An assessment of the resident's pain was not documented. Physician orders, dated 5/3/16, indicated, "Norco 10 mg-325 mg [a pain medication] [one] tab orally q [every] 6 hrs [hours] prn [as needed] pain," and "Admit to [name] Hospice Services." A facility care plan regarding pain control was not found in the clinical record. A Physician's order, dated 5/6/16, indicated, "Norco [one] q 6 [hours] routine." Progress Notes included the following notations: 5/7/16 at 8:04 A.M.: "Answered call light @ 6:30 A.M. - Res [resident] crying - 'I hurt so bad.' Administered routine meds."		*thequality assurance program by* the development and implementation of aQuality Assurance tool. This tool willmonitor the assessment and administration and thorough documentation of theadministration of pain medications to ensure each resident's pain is being controlled. The tool will also monitor to ensure that theresidents' care plans address the residents' pain needs. This tool will be completed by the Directorof Nursing and/or her designee daily for seven days, then weekly for threeweeks and then monthly for three months. The outcome of this tool will bereviewed at the facility's Quality Assurance meeting to determine if anyadditional action is warranted.	

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	Other documentation regarding the resident's pain was not found in the clinical record. The most recent progress note, dated 5/8/16, indicated, "Rec'd [sic] urine [culture and sensitivity] - notified hospice nurse - notified Dr...." The resident's Medication Administration Record (MAR) did not consistently document the resident's location of pain, what the level of pain was, or the results of the pain medication. On 5/10/16 at 11:15 A.M., the resident's hospice record was reviewed. A hospice note, dated 12:30 P.M., indicated, "...Pt [patient] has chronic lower back and bilateral leg pain. She has been on Norco 10 Q 6 Hours PRN for years...Pt reports pain is not really responding to Norco...HRN [hospice RN] left message for [name of physician] to discuss long-acting pain medication in place of frequent PRN dosing." A hospice care plan, dated 5/3/16, indicated, "Identified Problems, Patient experiencing pain...Interventions, Pain management regimen/medication, Monitor pain control...."			

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	The DON indicated at that time that an Interim Plan of Care should have been started upon admission. On 5/11/16 at 9:30 A.M., the DON provided the current facility policy on "Pain - Clinical Protocol," dated 3/6/15. The policy included: "The physician and staff will identify individuals who have pain or who are at risk for having pain...The nursing staff will assess each individual for pain upon admission to the facility...and when there is onset of new pain or worsening of existing pain...Staff will assess pain using a consistent approach and a standardized pain assessment instrument..." On 5/11/16 at 9:30 A.M., the DON provided the current facility policy on "Administering Pain Medications," dated 3/4/15. The policy included, "...Review the resident's care plan to assess for any special needs of the resident...'Pain management' is defined as the process of alleviating the resident's pain to a level that is acceptable to the resident...Acute pain should be assessed every 30 to 60 minutes after the onset and reassessed as indicated after analgesic relief is obtained...Upon admission...pain assessments are to be completed...Document the following in the resident's prn pain medication flow			

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	sheet: 1. results of the pain assessment; 2. medication; 3. dose...results of the medication...." This Federal tag relates to Complaint IN00198969. 3.1-37(a)			
F 0353 SS=E Bldg. 00	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial			

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	well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.			
	Based on observation, interview, and record review, the facility failed to ensure there was adequate staff to answer call lights timely, pass and pick up meal trays timely, feed residents timely, give showers at least twice weekly, change incontinent residents, and put residents to bed, for 3 of 3 residents reviewed for staffing, in a sample of 15. Residents A, Q, E; Family member # 1 and # 2; Staff # 1, # 2, # 3, and # 4. Findings include:	F 0353	F - 353 *1). The corrective action taken for those residents foundto be affected by the deficient practice is that* theresident identified as resident A is now receiving their call light answered ina timely manner including during meal service time. *2). The corrective action taken for those residents foundto be affected by the deficient practice is that* theresident identified as resident Q is now having their call light answeredtimely and is being put to bed in a timely manner at the resident'srequest. In addition the resident isreceiving their medications in a timely manner in accordance with the plan ofcare. *3). The corrective action taken for*	06/10/2016

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	On 5/9/16 at 8:30 A.M., upon facility entrance, the Social Services Director (SSD) indicated the facility had 50 residents. She indicated she was working on 1 hall, passing medications, as she was also a nurse. She indicated QMA # 1 was working on the other hall. The SSD indicated there were 2 CNAs who were working day shift. The SSD indicated the Administrator and Director of Nursing (DON) were not in the facility at that time. On 5/9/16 at 8:50 A.M. the DON entered the facility. The DON indicated there had been a change in management in the previous month, and staffing had "been kind of a struggle." The DON indicated there were students in a CNA class. On 5/9/16 at 10:40 A.M., during an interview with the facility's owner, he indicated he and the DON had worked the night shift the previous night. He indicated he and the Administrator had worked the 2nd shift the previous evening. He indicated he had other buildings, and staff would come in to assist as needed. The owner indicated he had people in CNA classes, and he was going to send out mailings to recruit staff. On 5/9/16 at 11:15 A.M., the Administrator provided a list of residents,		*those residents foundto be affected by the deficient practice is that* theresident identified as resident E is now receiving their showers in accordancewith their personal preference in time of day and frequency. *The corrective actiontaken for the other residents having the potential to be affected by the samedeficient practice is that* the facility has conducted a housewide auditrelated to each resident's personal preference as it relates to showers,bedtime and rising time. Thisinformation has been utilized to up-date the shower schedules and communicatedonto the CNA assignment sheets. Thefacility has successfully recruited additional nursing staff to ensure that allresident's needs such as timely answering of call lights, incontinentcare/toileting, administration of medications timely and honoring nap times orbedtime preferences are being met. *The measures or systematic changes that have been put intoplace to ensure that the deficient practice does not recur is that* the facility has on-going recruitment efforts whichwill be continued as well as providing regularly scheduled CNA classes toensure that the facility maintains adequate staffing to meet the needs of allresidents. In addition a mandatory allnursing staff in-service has been conducted related	

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	highlighting the interviewable residents. Residents A, Q, and E were highlighted as interviewable. On 5/9/16 at 1:45 P.M., the DON provided the nursing schedule for the previous 2 weeks. The schedule indicated generally: Day shift - 1 nurse and 1 QMA or nurse, 1-4 CNAs; Evening shift - 1-2 nurses or QMAs, 1-3 CNAs; Night shift - 1 nurse, 0-1 CNAs. On 5/9/16 at 1:45 P.M., the DON provided the CNA assignment sheets. The sheets indicated there were 50 residents in the facility. 14 residents were incontinent, and 27 residents required "Assist" with toileting. The CNA assignment sheets did not specify how many staff were required to assist the residents. The sheets indicated 5 residents required hoyer lifts (mechanical transfers), and 31 residents were in wheelchairs. 12 residents required assist with meals, and 3 were "dependent" for meals. On 5/9/16 at 4:25 P.M., the SSD indicated she was staying over to assist on 2nd shift, and the DON was also staying over. She indicated LPN # 2 and CNA # 1 was working and another CNA was coming in at 6:00 P.M. The DON indicated at that time that "the students		to ensure that allresident's personal preferences are honored. *The corrective actionwill be monitored to ensure the deficient practice will not recur through thequality assurance program by* the development and implementation of aQuality Assurance tool. This toolmonitors the following areas; timely answering call lights,toileting/incontinent care, showers being provided in accordance with personalpreference, rising/bedtime preferences and timely administration ofmedication. This tool will be completedby the Director of Nursing and/or her designee daily for seven days, thenweekly for three weeks and then monthly for three months. The outcome of thistool will be reviewed at the facility's Quality Assurance meeting to determineif any additional action is warranted.	

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	are coming back to help through supper." In an interview with Resident A, she indicated the facility "needed a way to keep their techs." She indicated it was very difficult to get her call light answered "during meal times especially." In an interview with Resident Q, she indicated staff will occasionally answer her call light, and after she tells staff what she wants, "they say they will come back but they never do." She indicated she frequently has to wait at least 1 hour after asking to lay down for staff to assist her. She indicated her medications were late "several times." She indicated she was supposed to get her medications 3 times a day, but that she sometimes "missed my noon dose." In an interview with Resident E, she indicated staff would bring her a basin with water for her to do her baths. She indicated she may have had a shower "once or twice," but not consistently. In a confidential interview with Family Member # 1, the family member indicated that residents were receiving medications late. The family member indicated her family member's call light was not answered timely, and the resident had to urinate in her pants instead of			

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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
	getting to the bathroom. The family member indicated the resident was not getting showers twice weekly. In a confidential interview with Family Member # 2, the family member indicated the facility was "short-handed." The family member indicated the resident would frequently be changed in the morning, and then no one would check the resident for the rest of the day. The family member indicated, "They are especially short on evenings." The family member indicated when the resident wanted to go to bed, the resident would frequently wait 2 hours after asking before staff was able to assist. In a confidential interview with Staff # 1, the staff member tearfully indicated, "We don't have any help. I'm so glad you're here." In a confidential interview with Staff # 2, the staff member indicated he/she had come on duty to find residents lying in soiled beds, and with untouched meal trays still in the rooms. He/She indicated, "It's been horrible. We can't get the showers done, we can't get call lights answered, we can't get residents turned or changed." Staff # 2 indicated, "You can't do it with 1 or 2 girls."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155801	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/11/2016

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TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

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	In a confidential interview with Staff # 3, the staff member indicated, "We had 90 % staff turnover." The staff member indicated there were occasions when he/she came on duty, he/she had to immediately change people and their beds "because they were in such a mess. It's bad." Staff # 3 indicated he/she had a resident inform him/her that the resident "laid in pee" for 3 days. In a confidential interview with Staff # 4, the staff member indicated, "It's been pretty rough. We do what we have to do for our residents." The staff member indicated medications were not always given on time. This Federal tag relates to Complaint IN00198969, Complaint IN00199528, and Complaint IN00199902. 3.1-17(a)			

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	155801		05/11/2016

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F 0441 SS=D Bldg. 00	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			

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NAME OF PROVIDER OR SUPPLIER TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH		STREET ADDRESS, CITY, STATE, ZIP CODE 305 E NORTH ST BOONVILLE, IN 47601	

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	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.			
	Based on observation, interview, and record review, the facility failed to ensure dressings were initialed and dated, for 2 of 3 residents reviewed with dressing changes, in a sample of 15. (Resident J, Resident B) Findings include: 1. On 5/9/16 at 8:40 A.M., during the initial tour, the Social Services Director indicated she thought Resident J had an open area on her buttocks. On 5/10/16 at 9:15 A.M., a skin assessment was requested. QMA # 1 assisted the resident to turn. A dressing was observed on the resident's right buttock. The dressing was neither dated, nor initialed. QMA # 1 indicated she did not know when the dressing was applied. On 5/10/16 at 1:00 P.M., the clinical	F 0441	F – 441 *1). The corrective action taken for those residents foundto be affected by the deficient practice is that* theresident identified as resident J is now receiving their wound treatment asordered and the dressing is dated and initialed by the nurses upon completionof each dressing change. *2). The correctiveaction taken for those residents found to be affected by the deficient practiceis that* the resident identified as resident Bis now receiving their peg tube dressing change as ordered and the dressing isdated and initialed by the nurses upon completion of each dressing change. *The corrective actiontaken for the other residents having the potential to be affected by the samedeficient practice is that* a house wide audit of all residents with treatmentdressing has been conducted. Eachresident is receiving their treatments/dressing changes in accordance with thephysician's orders and each	06/10/2016

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	record of Resident J was reviewed. A Physician's order, dated 1/6/16 and on the current May 2016 orders, indicated, "Collagen Hydrogel...Apply topically to open area on right buttocks after cleansing...Cover with bordered dressing daily and as needed if soiled." 2. On 5/9/16 at 8:40 A.M., during the initial tour, the Social Services Director indicated Resident B had a g-tube [a feeding tube]. The clinical record of Resident B was reviewed on 5/9/16 at 3:20 P.M. A Physician's order, dated 2/29/16 and on the current May 2016 orders, indicated, "Cleanse PEG tube [feeding tube] site daily w [with] soap & H2O & cover w/drsg [dressing]." On 5/9/16 at 5:00 P.M., an assessment of the resident's PEG tube site was requested. The DON assisted the resident. The resident had a dry gauze dressing around the PEG tube. The dressing was neither dated nor initialed. On 5/11/16 at 9:30 A.M., the DON provided the current facility policy on "Dressings, Dry/Clean," undated. The policy included, "...Apply the ordered		dressing is dated and initialed upon completion ofthe dressing change. *The measures or systematic changes that have been put intoplace to ensure that the deficient practice does not recur is that* the facility has reviewed and revised their policyand procedure on dressing changes. Amandatory in-service has been provided for all licensed nurses on the facilitypolicy related to dressing changes. Aspecial focus was given to the dating and initialing of each dressing change inaccordance with facility policy. *The corrective actionwill be monitored to ensure the deficient practice will not recur through thequality assurance program by* the development and implementation of aQuality Assurance tool. This tool willmonitor to ensure that residents are receiving dressing changes in accordancewith their physician's orders which includes the dating and initialing of thedressing upon completion of each dressing change. This tool will be completed by the Directorof Nursing and/or her designee daily for seven days, then weekly for threeweeks and then monthly for three months. The outcome of this tool will be reviewedat the facility's Quality Assurance meeting to determine if any additionalaction is warranted.	

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	dressing and secure with tape...Upon application of the dressing place the date with a black marker or pen on the dressing...." This Federal tag relates to Complaint IN00198969. 3.1-18(a)			