STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155668	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 09/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF PROVIDENCE LLC	4915 CHARLESTOWN RD NEW ALBANY, IN 47150

(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
F000000	This visit was for the Investigation for Complaint IN00136391. Complaint IN00136391 - Substantiated. Federal/state deficiencies related to the allegations are cited at F225, F226, F272, F323, and F514. Survey dates: September 16 and 17, 2013 Facility number: 001144 Provider number: 155668 AIM number: 200256980 Survey team: Diana Sidell RN Census bed type: SNF: 47 SNF/NF: 67 Residential: 6 Total: 120 Census payor type: Medicare: 23 Medicaid: 38 Other: 59 Total: 120 Sample: 3	F000000	This plan of correction constitutes Diversicare of Providence credible allegation of compliance for the cited deficiencies. Nothing in the plan of correction should be construed as admission by the facility of any violation of state and federal statues, regulations or standards of care. This plan of correction is to demonstrate compliance of the state and federal requirements cited during the annual survey.	

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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	These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on September 26, 2013 by Cheryl Fielden, RN			

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	155668		09/17/2013

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F000225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record review and	F000225	1) What corrective action(s) will	10/17/2013

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	interview, the facility failed to thoroughly investigate an episode of bruising from an unknown origin. This affected 1 of 3 residents in a sample of 3. (Resident #A) Findings include: Resident #A's record was reviewed on 9/16/13, at 12:15 p.m. The record indicated Resident #A was admitted with diagnoses that included, but were not limited to, coronary artery disease, Parkinson's disease, high blood pressure, atrial fibrillation, and dementia. Nurse's Notes, dated 4/1/13 at 5:12 p.m., indicated: "Daughter in & noticed Bruise to (L) hand. [No] pain to area. Res unable to tell this nurse how bruise occurred." Further review of Resident #A's record failed to indicate an investigation or explanation for the bruise. During an interview, on 9/17/13 at 1:15 p.m., the Administrator indicated the bruising on Resident #A's left hand was not investigated and that he frequently had bruising. A policy and procedure for "Resident/Abuse", with an approval date of 11/15/11, was provided by the		be accomplished for those residents found to have been affected by the deficient practice;Unable to correct for resident #A due to resident being discharged from facility.2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.Facility will complete a 100% audit on skin assessments to verify that there are no bruising of unknown origins that hasn't been investigated.3) What measures will be put into place or what systemic changes will be made to ensure that the deficiant practice does not recur;Licensed staff will be in-serviced on investigating and reporting bruising of unknown origins.Director of Nursing/Designee will audit 100% percent for one week, then 20% weekly for one month, 20% monthly for two months and then 20% quarterly for the remainder of the year.4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.Director of Nursing/Designee will audit 100% for one week, 20% weekly for one month, 20% monthly for two months and then 20% quarterly for the remainder of the year. Findings will be reported to the QI committee.	

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	Administrator, on 916/13 at 11:35 a.m. The policy indicated, but was not limited to, "Policy Statement: Each resident has the right to be free from mistreatment, neglect and misappropriation of property...IV. Identification: A. Residents who have suspicious bruising, particularly of the face, arms, abdomen and shins, will have such bruising assessed by nursing...Staff will be alert for patterns, occurrences and trends that may constitute abuse...When an incident or suspected incident of resident abuse, neglect, misappropriation of resident property, or injury of unknown origin is reported, the administrator will appoint a staff member to investigate the incident...The investigation shall consist of: Review of statement made by the person reporting the incident; Interview with the person(s) reporting the incident; Interview with any witness to the incident...The results of the investigation will be recorded...." This Federal Tag relates to Complaint IN00136391. 3.1-28(c)			

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F000226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to implement their policy for abuse, in that one incident of bruising from an unknown origin was not investigated. This affected 1 of 3 residents in a sample of 3. (Resident #A) Findings include: Resident #A's record was reviewed, on 9/16/13 at 12:15 p.m. The record indicated Resident #A was admitted with diagnoses that included, but were not limited to, coronary artery disease, Parkinson's disease, high blood pressure, atrial fibrillation, and dementia. Nurse's Notes, dated 4/1/13 at 5:12 p.m., indicated: "Daughter in & noticed Bruise to (L) hand. [No] pain to area. Res[ident] unable to tell this nurse how bruise occurred." Further review of Resident #A's record failed to indicate an investigation or explanation for the bruise.	F000226	1) What corrective action(s) will be accompllished for those residents found to have been affected by the deficient practice;Unable to correct for resident #A due to resident being discharged from the facility. 2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Facility will complete a 100% audit on skin assessments to verify that there are no bruising of unknown orgins that hasn't been investigated.3) What measures will be put into place or what systemic changes will be made to ensure that the deficiant practice does not recur;Licensed staff will be in-serviced on investigating and reporting bruising of unknown origins. Director of Nursing/Designee will audit 100% for one week, then 20% weekly for one month, 20% monthly for two months and then 20% quarterly for the remainder of the year. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put	10/19/2013

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	During an interview, on 9/17/13 at 1:15 p.m., the Administrator indicated the bruising on Resident #A's left hand was not investigated and that he frequently had bruising. A policy and procedure for "Resident/Abuse", with an approval date of 11/15/11, was provided by the Administrator on 916/13 at 11:35 a.m. The policy indicated, but was not limited to, "Policy Statement: Each resident has the right to be free from mistreatment, neglect and misappropriation of property...IV. Identification: A. Residents who have suspicious bruising, particularly of the face, arms, abdomen and shins, will have such bruising assessed by nursing...Staff will be alert for patterns, occurrences and trends that may constitute abuse...When an incident or suspected incident of resident abuse, neglect, misappropriation of resident property, or injury of unknown origin is reported, the administrator will appoint a staff member to investigate the incident...The investigation shall consist of: Review of statement made by the person reporting the incident; Interview with the person(s) reporting the incident; Interview with any witness to the incident...The		into place. Director of Nursing/Designedd will audit 100% for one week, 20% weekly for one month, 20% monthly for two months and then 20% quarterly for the remainder of the year. Findings will be reported to the QI committee.	

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	results of the investigation will be recorded...." This Federal Tag relates to Complaint IN00136391. 3.1-28(a)			

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F000272 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.			
	Based on interview and record review, the facility failed to complete skin assessments on residents with bruises and skin tears for 2 of 3 residents reviewed. (Residents #B	F000272	1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;Unable to go back and complete on resident #B but a	10/17/2013

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	and #C) Findings include: 1. Resident #B's record was reviewed on 9/16/13 at 2:20 p.m. The record indicated Resident #B was admitted with diagnoses that included, but were not limited to, stroke with left sided weakness, history of right hip fracture, high blood pressure, Alzheimer's disease, osteoporosis, and dementia. Nurse's notes, dated 7/27/13 at 4:45 p.m., indicated: "CNA called this nurse to Res's (Resident's) (rm). Found Res lying on floor next to bed on (R) side - Denies pain - but did hit head during fall - neuro [checks] started. Noted SR (side rail) [down] & alarm not sounding - Therapist stated that [resident was] brought back from therapy & assisted to bed @ abt (about) 3:40 p.m. & that she thought SR's [up] but couldn't be sure...." A "Skin/wound Assessment", dated 7/27/13, indicated on a diagram that the resident had a bruise on her right forehead, a skin tear on the left lower leg, and a skin tear on the right elbow. The information written at the top of the assessment form indicated: "Using the diagrams provided,		current assessment will be completed.Unable to go back and complete on resident #C but a current assessment will be completed.2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;Facility will complete a 100% audit of skin assessments for completion per the directions on the skin assessment form.3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;Licensed staff will be in-serviced on completing the skin assessment form per the directions on the form.Director of Nursing/Designee will audit for completion of the skin assessment forms per directions on the form at 100% for one week, 20% weekly for one month, 20% monthly for two months and then 20% quarterly for the remainder of the year.4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.Director of Nursing/Designee will audit 100% for one week, 20% weekly for one month, 20% monthly for two months and then 20% quarterly for the remainder of year for completion of skin assessments completion per the directions on the assessment form. Findings	

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	indicate all body marks as checked. Include old recent scars (surgical and others), bruises, discolorations, abrasions, pressure ulcers, skin tears, lacerations or questionable markings. Indicate size, depth, color or drainage." The assessment failed to include the size and color of the bruise, and the size, depth, and if any drainage of the skin tears. 2. Resident #C's record was reviewed on 9/17/13 at 11:00 a.m. The record indicated Resident #C was admitted with diagnoses that included, but were not limited to, dizziness, chronic atrial fibrillation, high blood pressure, chronic renal insufficiency, osteoarthritis, depression, and anxiety. Nurse's Notes dated 8/11/13 at 10:00 a.m. indicated Resident #C had fallen and had a gash to her upper left arm with small bruises, and at 10:15 a.m. found bruising and swelling to the left lower extremity and a small bruise to the right lower extremity. A "Skin/wound Assessment", dated 8/13/13, indicated on a diagram that the resident had bruising and a skin tar on the upper left arm, bruising on the lower left leg, and a "hematoma		will be reported to the QI committee.	

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	knot" on the lower right leg. The information written at the top of the form indicated: "Using the diagrams provided, indicate all body marks as checked. Include old recent scars (surgical and others), bruises, discolorations, abrasions, pressure ulcers, skin tears, lacerations or questionable markings. Indicate size, depth, color or drainage." The assessment failed to include the size and color of the bruises, and the size, depth, and if any drainage of the skin tear. An undated skin/wound assessment indicated a skin tear and bruising on the upper left arm, and bruises on both lower legs, and failed to include the size, depth, color or drainage of the skin tear and bruises. On 9/17/13 at 12:55 p.m., the Director of Nurses indicated they measure pressure ulcers weekly, but do not measure bruising and lacerations to follow their progression; they measure them initially. She indicated it is documented in the nurse's notes and they don't measure bruises typically, just initially, and they use landmarks [bone and soft tissue structures]. This Federal Tag relates to Complaint IN00136391.			

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	3.1-31(d)(3)			

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F000323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to ensure that each resident received adequate supervision and assistance devices to prevent accidents in that one resident sustained a fall that resulted in a large amount of bruising after being left unattended in bed, with the half side rail down, and the personal safety alarm unhooked and turned off. This affected 1 of 3 residents reviewed for falls in a sample of 3. (Resident #B) Findings include: Resident #B's record was reviewed on 9/16/13 at 2:20 p.m. The record indicated Resident #B was admitted with diagnoses that included, but were not limited to, stroke with left sided weakness, history of right hip fracture, high blood pressure, Alzheimer's disease, osteoporosis, and dementia. A quarterly Minimum Data Set Assessment (MDS), dated as	F000323	1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficiant practice;Unable to go back and correct for Resident #B.2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.Facility will complete a 100% audit of residents to verify that bed alarms are on and functioning when in bed and that quarter side rails are up as ordered.3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;Therapy staff will be in-serviced on placing bed alarms and quarter side rails up per ordered when returning residents back to their rooms after therapy./Director of Nursing/Designee will audit 100% for one week, 100% weekly for one month, 100% weekly for two months, and then 100% quarterly for the remainder of year for bed alarm functioning while resident is in bed and quarter side rails up as ordered.4) How the corrective action(s) will be monitored to	10/17/2013

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	completed on 8/06/13, indicated Resident #B was severely impaired, never/rarely made decisions in cognitive skills for daily decision making, required extensive assist of two or more persons for bed mobility and transfers, and did not ambulate. The MDS also indicated Resident #B has had two falls with injuries that included; skin tears, abrasions, lacerations, superficial bruises, hematomas, or sprains, since the prior assessment. A fall risk assessment dated 7/23/13 indicated a total score fall risk of 40 where a total score of 25 or over is a high risk or falls. A fall risk assessment dated 7/27/13 indicated a total score fall risk of 60. A care plan for falls, with a last review date of 8/8/13, indicated interventions that included, but were not limited to, dycem to wheel chair and recliner, enabling devices as needed, and sensor alarm to bed and wheel chair at all times. Nurse's notes, dated 7/27/13 at 4:45 p.m., indicated: "CNA called this nurse to Res's (Resident's) (rm). Found Res lying on floor next to bed on (R) side - Denies pain - but did hit		ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.Director of Nursing/Designee will audit 100% for one week, 100% weekly for one month, 100% weekly for two months, then 100% quarterly for the remainder of the year for bed alarm functioning while resident is in bed and quarter side rails up as ordered. Finding will be reported to the QI committee.	

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NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF PROVIDENCE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 4915 CHARLESTOWN RD NEW ALBANY, IN 47150	

(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
	head during fall - Neuro [checks] started. Noted SR (side rail) [down] & alarm not sounding - Therapist stated that [resident was] brought back from therapy & assisted to bed @ abt (about) 3:40 p.m. & that she thought SR's [up] but couldn't be sure - Neuro [checks] WNL (within normal limits) - Call to POA - informed of fall...." Nurse's notes, dated 7/27/13 at 5:04 p.m., indicated: "Call to [Resident's physician] - updated on Res's condition - N/O's (new orders) for X-ray of (R) arm & (R) hip - Res. ref. to keep ice pack to hematoma on (R) forehead. Doesn't want to be bothered [with] V/S's (vital signs) but will comply when explained that we need to do so. Denies pain to head." Nurse's notes, dated 7/27/13 at 7:00 p.m., indicated: "X-ray Tech here & X-ray done." Nurse's notes, dated 7/27/13 at 9:30 p.m., indicated: "X-ray returned [with no] frx (fracture)." Nurse's notes, dated 7/27/13 at 8:00 p.m., indicated: "Res. denies pain or discomfort - Bruise to (R) side of forehead & around eye - [up] in w/c for supper."			

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	Nurse's notes, dated 7/29/13 at 3:00 p.m., indicated: "...Hematoma remains to (R) forehead & residual bruising to (R) side of face. Large bruise remains to (R) elbow. Drng (dressing) intact covering skin tear - [no] co pain or discomfort...." Rehabilitation screening form, dated 7/29/13, indicated: "...1. Comments: Fall was isolated incident with pt (patient) in bed [without] alarm & [without] side rail up. Pt is on Therapy caseload." On 9/17/13 at 2:30 p.m., the Administrator indicated they had done teaching with the Therapist who had left the resident in bed and had not put the side rail up or the alarm in place. A policy for "Assessing Falls and Their Causes", with a last review date of 4/2113, was provided by the Director of Nurses on 91613 at 11:46 a.m. The policy indicated, but was not limited to, "The purposes of this procedure are to provide guidelines or assessing a resident after a fall and to assist staff in identifying causes of the fall. 1. Assess resident for injury and provide any necessary treatment...3. Document the occurrence in the medical record...Implement			

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	interventions to reduce risk of additional falls. Review and revise if necessary the plan of care...." This Federal Tag relates to Complaint IN00136391. 3.1-45(a)(2)			

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F000514 SS=A	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview the facility failed to ensure complete and accurate documentation in clinical records in that skin/wound assessment forms were undated for 1 of 3 residents reviewed. (Resident #C) Findings included: Resident #C's record was reviewed on 9/17/13 at 11:00 a.m. The record indicated Resident #C was admitted with diagnoses that included, but were not limited to, dizziness, chronic atrial fibrillation, high blood pressure, chronic renal insufficiency, osteoarthritis, depression, and anxiety.	F000514	1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;Current skin assessment to be completed on Resident #C2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;Facility will complete a 100% audit of skin assessments for completion per the directions on the skin assessment form.3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;Licensed staff will be in-serviced on completing the skin assessment form per the directions on the form.Director of Nursing/Designee will audit for completion of the skin	10/17/2013

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	Nurse's Notes dated 8/11/13 at 10:00 a.m. indicated Resident #C had fallen and had a gash to her upper left arm with small bruises, and at 10:15 a.m. found bruising and swelling to the left lower extremity and a small bruise to the right lower extremity. A skin/wound assessment was undated and indicated two bruises on the left lower leg. An undated skin/wound assessment indicated a skin tear and bruising on the upper left arm, and bruises on both lower legs, and failed to include the size, depth, color or drainage of the skin tear and bruises. On 9/17/13 at 12:55 p.m., the Director of Nurses indicated they measure pressure ulcer weekly, but do not measure bruising and lacerations to follow their progression, they measure them initially. She indicated it is documented in the nurse's notes, they don't measure bruises typically, just initially, and they use landmarks [bone and soft tissue structures]. A policy for "Charting and Documentation" was provided by the Administrator on 9/17/13 at 2:43 p.m. The policy indicated, but was not limited to; "All services provided to the		assessment forms per directions on the form at 100% for one week, 20% weekly for one month, 20% monthly for two months and then 20% quarterly for the remainder of the year.4) How the corrective action action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.Director of Nursing/Designee will audit 100% for one week, 20% weekly for one month, 20% monthly for two months and then 20% quarterly for the remainder of the year for completion of skin assessment completion per the directions on the assessment form. Findings will be reported to the QI committee.	

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	resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record...6. Documentation of procedures and treatments shall include care-specific details and shall include a minimum: a. The date and time the procedure/treatment was provided...." This Federal Tag relates to Complaint IN00136391. 3.1-50(a)(1)			