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	155490	A. BUILDING 00 B. WING	07/24/2017

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AMBASSADOR HEALTHCARE	705 E MAIN ST CENTERVILLE, IN 47330

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: July 18, 19, 20, 21, and 24, 2017 Facility number: 000456 Provider number: 155490 AIM number: 100288750 Census bed type: SNF/NF: 116 Total: 116 Census payor type: Medicare: 9 Medicaid: 87 Other: 20 Total: 116 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on July 28, 2017	F 0000		

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

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F 0282 SS=D Bldg. 00	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) 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 administer two topical treatments to open areas on a resident's face as ordered by the physician for 1 of 3 residents reviewed for skin condition (non pressure) (Resident 62). Finding include: During observation on 7/19/17 at 11:06 a.m., Resident 62 had open areas to both sides of her face and was constantly picking at these areas with her hands. During observation and interview on 7/19/17 at 11:10 a.m., CNA 5 indicated it	F 0282	F 282 SERVICES BY QUALIFIED PERSONS/PER CARE PLAN I. Resident #62 had not only topical treatments as needed, but oral treatments due to her behavior of picking her face. On 6/7/17, Resident #62 received an order from Dr. Patel, facility psychiatrist, for Ativan 0.5mg bid. On 6/12/17, Dr. Patel contacted and Depakote order received. On 6/19/17, a helmet and	08/23/2017

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	was normal for Resident 62 to pick at her face, it got really bad sometimes. The resident had blood on her hands and had open sores on both sides of her face that were bleeding. CNA 5 assisted the resident to the bathroom. The July 2017 physician recapitulation for Resident 62, the resident was ordered bacitracin zinc ointment 500 units/gram apply to left side of face topically every one hour as needed for itching and picking at skin apply ointment to sores on her two times a day (original order date 2/15/17). The resident was ordered skin adhesive liquid apply to picked areas on face topically every 8 as needed for picked open areas on face apply topically to open areas on face as needed for healing and prevention of resident further picking areas open (original order date 3/21/17). A review of the record of Resident 62 on 7/21/17 at 9:57 a.m., indicated the resident's diagnoses included, but were not limited to, Alzheimer disease, dementia, osteoarthritis, myocardial infarction, anemia, major depression disorder, diabetes, anxiety and malnutrition. The progress note for Resident 62, dated 5/27/17 at 5:47 a.m., the resident was		hand mitts were tried, but resident could remove them. On 6/28/17, Depakote was increased due to picking. On 7/12/17, resident was started on Risperdal Consta 25mg IM every 14 days and Ativan was discontinued. On 7/30/17, 1 small area remained and Bacitracin was changed to bid routinely. II. Current residents residing at the facility who have topical treatments to open areas due to picking were reviewed by the wound nurse and Director of Nurses to ensure that all other residents are being treated appropriately. III. A systematic change includes those residents with open areas due to picking will have routine treatments instead of as needed. Education and training will be provided to all licensed staff regarding the use of topical treatments.	

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	scratching at the right and left side of face. The resident had reopened a sore on the left side of her face. The resident's hands and face were cleaned and bacitracin applied to open area. The progress note for Resident 62, dated 6/7/17 at 9:00 a.m., indicated the resident had been picking at her skin causing open sores on her face and arm. Treatment to her face per order. The resident continues to pick at her face. The progress note for Resident 62 dated 6/7/17 at 8:53 a.m., the resident had recurrent behavior of face picking, causing multiple open wounds to her face, forehead/cheeks. "Marathon and bacitracin as needed to areas, but picks medication off and starts picking at new places." The progress note for Resident 62, dated 6/10/17 at 7:57 p.m., indicated the resident had profuse bleeding on her left cheek. Two washcloths were placed to stop bleeding. The area was cleansed and a dressing applied. The progress note for Resident 62, dated 6/13/17 at 9:43 a.m., the resident continues to pick at face, causing open sores.		IV. The Director of Nurses and Wound Nurse will audit topical treatment orders by random observation. These audits will be provided at a minimum of 5 per week for 4 weeks and then a minimum of 5 per month for an additional 5 months. Any identified concerns from audits will be addressed immediately. V. The results of these audits will be discussed at the facility Quality Assurance Performance Improvement meeting and frequency and duration of reviews will be adjusted as needed. Completion Date: August 23, 2017	

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	The progress note for Resident 62, dated 6/13/17 at 9:50 p.m., the resident had been picking at her face and now had open areas in several places. The progress note for Resident 62, dated 6/14/17 at 11:00 a.m., the resident continues to pick at her face causing open sores. The progress note for Resident 62, dated 6/16/17 at 5:55 a.m., the resident continued to pick at her face throughout the night. The resident's blood was cleaned up and changed her clothes twice. A dressing was applied to an area on one side of left face where resident continually picks. The progress note for Resident 62, dated 6/25/17 at 7:10 p.m., the resident shoved her finger into her right cheek wound causing it to bleed. The progress note for Resident 62, dated 6/29/17 at 4:24 a.m., the resident continued to scratch and pick at her face. The progress note for Resident 62, dated 6/29/17 at 9:35 a.m., the resident continued to pick at her face causing sores and large amount of bleeding. The resident's clothes were changed twice this morning due to being blood soaked			

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	related to picking her skin. The progress note for Resident 62, dated 6/29/17 at 2:00 p.m., the resident was having a negative behavior of clawing at her face and drawing blood. The progress note for Resident 62, dated 6/29/17 at 10:04 p.m., the resident removed dressing from her face and began picking at her face, a dressing was reapplied. The progress note for Resident 62, dated 6/30/17 at 5:47 a.m., the resident began digging at her face causing a large amount of blood to drain. The progress note for Resident 62, dated 7/5/17 at 10:17 a.m., the resident was in the dining room and began picking sores on her face causing them to bleed. The progress note for Resident 62, dated 7/13/17 at 9:24 p.m., the resident continued to pick at her face. During observation on 7/21/17 at 11:46 a.m., Resident 62 was sitting in her recliner she had two open sores on the right side of her face and two open sores on the left side of her face. The areas were open and bloody. The resident had blood on her clothes and dried dark			

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	substance on her recliner. Review of the Medication Administration Record (MAR) for Resident 62, dated May 2017, June 2017 and July 2017, the resident was not administer the physician ordered treatment for the bacitracin or the skin adhesives. Interview with CNA 5 on 7/24/17 at 1:11 p.m., Resident 62 had been picking at her face for a long time. The CNA tried to put long sleeves on the resident to prevent the resident from picking at her arms and tried to redirect the resident by bringing her out of her room, but the resident would refuse most of the time. Interview with LPN 4 on 7/24/17 at 1:15 p.m., was unable to find documentation that Resident 62 had been provided the physician ordered treatments to the open areas on her face. 3.1-35(g)(1)			
F 0284 SS=D Bldg. 00	483.21(c)(1)(2)(iv) ANTICIPATE DISCHARGE: POST-DISCHARGE PLAN (c)(1) Discharge Planning Process			

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	The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving			

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	information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's			

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	representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. (c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. Based on observation, interview and record review the facility failed to assist a resident with discharge planning as ordered by the physician and per resident's preference for 1 of 1 resident reviewed for transfer/discharge rights (Resident 65). Finding include: Interview with Resident 65 on 7/18/17 at 1:25 p.m., the facility had not talked to her about discharge planning. The	F 0284	F284 ANTIPATE DISCHARGE: POST-DISCHARGE PLAN I. BSW met with Resident #65 on 7/24/17, 7/26/17, 7/31/17, 8/1/17, 8/2/17, 8/3/17, 8/8/17, and 8/9/17 to assist with discharge planning. Referral made to assisted living facility on 7/17/17. Inquires made to (2) assisted living facilities on	08/23/2017

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	resident was considering seeking legal counsel to assist her with discharging to an assisted living facility. The resident had been at the facility five months and no one had talked to her about her discharging. The resident felt she was being kept at the facility against her will. The resident had been living independently in an apartment before coming to the facility, she got dehydrated and had "bladder infection" and was sent to the hospital. The resident's doctor had signed a release for her to discharge and she was unsure why no one was assisting her. The resident desired to go to a local assisted living facility as she did not require nursing care and wanted to be around residents that she had more things in common with. Review of the record of Resident 65 on 7/21/17 at 11:15 a.m., indicated the resident's diagnoses included, but were not limited to, Alzheimer disease, insomnia, dementia, major depression disorder, hypertension, anxiety and chronic kidney disease. intact to make decisions regarding daily life task. The resident had no behaviors, including wandering. The resident required supervision of one person for all activities of daily living (ADL's). The Quarterly Minimum Data Set (MDS) assessment for Resident 65, dated		7/24/17. Resident had declined to proceed with 11 apartments and/or assisted living facilities proposed to her. Care plan written to reflect discharge plan on 7/24/17. Referral made to local AAA on 8/4/17 to assess for Medicaid Waiver. Meeting held with local Ombudsman on 8/4/17 to consult on discharge planning. Discharge care plan meeting held with Resident #65 and her daughter on 8/7/17. Meeting held with IDT on 8/8/17 and 8/10/17 to assist her with Medicaid application process in accordance to discharge plan. Resident #65 completed application for one apartment complex on 8/9/17. She has been uncooperative to date in assigning life insurance over to funeral home to meet requirements for Medicaid eligibility. II. Current residents residing in the facility will be assessed for discharge planning. All	

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	6/24/17, the resident had clear speech and could make herself understood and had the ability to understand others. The resident was cognitively The record indicated Resident 65 was admitted to the facility on 3/13/17. The plan of care for Resident 65, dated 3/21/17, "Resident is long term placement at this time. " Resident does not wish to be asked about returning to the community on all assessments, but rather annually or if there is a significant change in condition. The local psychiatrist note for Resident 65, dated 5/29/17, the resident was alert, orientated to person, place and time. The resident was depressed, her thought process was organized and appropriate. The resident reports feeling depressed and unhappy. The resident reported she would never be happy at the facility and would like to live in the local independent living facility. The physician order for Resident 65, dated 6/28/17 (no time), "Social services to work with her on discharge options". The local psychiatrist note for Resident 65, dated 7/11/17, the resident was alert, orientated to person, place and time. The		those anticipating discharge will have physicians notified and plan of care will be updated at that time. III. A systematic change includes a weekly meeting with social service department and the nurse doing rounds with Medical Director to discuss any referral/orders for discharge. Plan of care will be updated at that time. Copy of “CMS Right to Get Information about Returning to the Community” form will continue to be incorporated into the admission packet as well as posted visibly on each unit. IV. Social services and/or designee will monitor the residents with discharge planning by random observation. These audits will be provided at a minimum of 5 per week for 4 weeks and then a minimum of 5 per month for an additional 5 months. Any identified concerns from audits will be addressed.	

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	resident's thought process was organized and appropriate. The resident reports feeling frustrated with her delay in discharge planning and needed to find different placement. The Social Service progress note for Resident 65, dated 7/19/17 at 11:19 a.m., "investigating independent living arrangements for resident per doctor's order and resident request." Called a local independent living facility and left a message to return my call. The resident also requested other area housing be contacted. Interview with Resident 65 on 7/24/17 at 11:29 a.m., the resident required no assistance from staff for showering, ambulating or any activities of daily living (ADL's). Social Services had not talked to her about discharge planning. The Social Service Director (S.S.D.) 6 had talked with her early in the day, but had not talked to her about discharging to another facility. Interview with S.S.D. 6 on 7/24/17 at 11:38 a.m., she had talked with Resident 65 about discharge planning, but had not documented it. S.S.D. 6 had made a list of places to look into for Resident 65 to discharge. S.S.D. 6 had not updated the resident's plan of care for the resident's		V. The results of these audits will be discussed at the facility Quality Assurance Performance Improvement meeting and frequency and duration of reviews will be adjusted as needed. Completion Date: August 23, 2017	

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	current preference to discharge to an assisted living facility. The resident was her own person and did not have a Power Of Attorney (POA). LPN 4 had contacted S.S.D. 6 this morning and reported Resident 65 "really wanted to talk to me about discharging." S.S.D. 6 did receive the physician order dated 6/28/17 to assist the resident with discharging. During interview and observation with Resident 65 on 7/24/17 at 12:53 p.m., the resident's family was supportive of her discharging to an assisted living facility. The resident was independent with all her ADL's. The only assistance she required from staff was medication administration. There were a lot of former co workers living at one of the local assistive living facilities and she desired to move there so she could be around her friends. The resident did not have a POA. S.S.D. 6 had come to her a few minutes ago and told her there had been some miscommunication about her discharge planning. The facility physician had been supportive on her decision to move to an independent living facility and she was not sure why it had took so long "to get things going for a different place." During this interview the resident got up from her bed and walked to her lamp to turn the light on. The resident was stable with transferring and ambulation.			

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	Interview with LPN 4 on 7/24/17 at 1:26 p.m., Resident 65 had expressed her desire to discharge since her admission to the facility and the resident had reported it to any staff she could. The resident was independent with "everything" ADL's, showers etc. The resident did require medication administration. The resident was confused when she first admitted to the facility, as she had an Urinary Tract Infection (UTI) and was dehydrated, the resident had not been confused since her admission. The resident had not displayed behaviors of wandering or exit seeking. The transfer and discharge policy provided by S.S.D. 6 on 7/24/17 at 12:30 p.m., "Social service staff will work with the interdisciplinary team to ensure that transfers and discharges occur in such a manner as to maintain or improve the resident's physical, mental and psychosocial well being." 3.1-36(a)(3)			
F 0309 SS=D Bldg. 00	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING			

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	155490	A. BUILDING 00 B. WING	07/24/2017

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	483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. 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, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on observation, record review, and interview, the facility failed to:	F 0309	F309 PROVIDE CARE/SERVICES FOR HIGHEST WELL-BEING	08/23/2017

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	A. Ensure all areas on pain assessments were completed for 2 of 3 residents reviewed for pain management (Residents 123 and 127), and B. Failed to document, and report to the wound nurse, an area of bruising, and failed to develop a plan of care related to bruising for 2 of 3 residents reviewed for non pressure related skin problems. (Residents 95 and 134). Findings include: A. 1. During an interview, on 7/19/2017 at 9:49 a.m., Resident 123 said his right hip hurts all the time, they give him pain medicine but it doesn't help. On 7/20/2017 at 10:48 a.m., Resident 123 was seated in his recliner in his room watching television. He said his pain was not too bad this morning, "was manageable". Resident 123's record was reviewed on 7/20/2017 at 10:58 a.m. The record indicated Resident 123 had had diagnoses that included, but were not limited to, depression, rheumatoid arthritis, acute ischemic heart disease, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side generalized muscle weakness, unsteadiness on feet, and right hip fracture with repair		I. Resident 123 and 127 pain assessment was immediately completed with no changes in either residents pain medication. II. Resident 95 and 134 bruises were immediately assessed, reported to wound nurse, and care plan developed. III. Current residents residing at the facility will be assessed for pain and receive an updated pain assessment. Those identified exhibiting pain will have physician notified and receive treatment as ordered. Plan of care will be updated at that time. IV. Current residents residing in the facility will be reassessed for bruises. Those identified with bruises will have investigation completed per policy and plan of care will be updated at that time.	

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	(6/26/17). A Significant Change Minimum Data Set (MDS) assessment, dated 7/11/17, indicated Resident 123 was moderately impaired in cognitive skills for daily decision making, a pain assessment interview should be conducted, the resident has had occasional pain or hurting in the last 5 days, that has not made it hard to sleep at night and has not had to limit his day-to-day activities because of pain and on a pain scale of 1 - 10, his pain intensity was 7. Pain Evaluations, dated 10/6/16, 1/9/17, and 4/10/17, and 7/9/17 had the area at the top of the first page completed that indicated the resident had a diagnosis "which would give reason to believe he/she would be in pain Yes" and that diagnosis was rheumatoid arthritis. The areas for the date of onset, description of the pain, symptoms associated with the pain, if there is something that increases the pain, a time the pain is worse, the entire section for pain location/type/frequency/intensity/duration , an objective evaluation for breathing, negative vocalization, facial expression, and body language and consolability were not completed. The second page did not have the "Pain Effect on Function", Nonverbal/noncognitive Signs of Pain,		V. A systematic change includes that education on pain are now included on the annual in-service calendar. Education and training will be provided to licensed staff on completion of assessments, PAINAD Scale, and policy on pain. VI. All nursing staff was educated on skin assessments. Education included when skin assessments are to be done, notifying wound nurse of any skin concerns including skin tears, red area, bruises, and scratches even if it has been visualized before. Skin concerns will be documented on the weekly shower sheets by C.N.A.'s and weekly skin assessments by licensed staff. All nursing staff will notify the wound nurse of all skin concerns whether old or new. VII. The Director of Nurses, and/or designee	

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	Relief of Pain", or the conclusion for the pain assessment completed. On 7/24/2017, at 1:40 p.m., MDS Coordinator 1 said all the areas on the Pain Evaluation form should have been completed. A. 2. During an interview, on 7/18/2017 at 1:47 p.m., Resident 127 said her right knee and her left hip "hurt all the time". Resident 127's record was reviewed on 7/21/2017 at 9:10 a.m. The record showed that Resident 127 had diagnoses that included, but were not limited to, Alzheimer's disease, depression, anxiety, rheumatoid arthritis, and generalized muscle weakness. A Quarterly MDS, 5/6/17, indicated Resident 127 was cognitively intact, she receives scheduled and routine pain medications, non-medication interventions for pain, a pain interview assessment should be conducted, and showed pain was present, has occasional pain that didn't make it hard to sleep at night, it didn't limit her day to day activities, and her pain, on a pain scale of 0-10, was assessed as 5. A "Pain Evaluation", dated 5/5/17, indicated the form was incomplete in the		will provide a clinical record review of pain assessments by random order. These audits will be provided at a minimum of 5 per week for 4 weeks then a minimum of 5 per month for an additional 5 months. Any identified concerns from audits will be addressed immediately. VIII. The Director of Nurses and Wound Nurse will audit skin concerns by random observation through showers and nursing skin assessments. These audits will be provided at a minimum of 5 per week for 4 weeks then a minimum of 5 per month for an additional 5 months. Any identified concerns from audits will be addressed immediately. IX. The results of these audits will be discussed at the facility Quality Assurance Performance Improvement meeting and frequency and duration of reviews will be	

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	following areas: the section for pain "location/type/frequency/intensity/duratio n" was not completed, the section for non medication interventions was not completed, the question for medication relief was not completed, nor the time elapsed until the resident's pain was relieved, and the conclusion of the pain assessment was not completed. A "Pain Evaluation", dated 2/14/17 was incomplete in these areas: the top of the pain evaluation was not filled out where it asked if the resident has had pain or hurting at any time in the last 5 days, as well as the section for pain "location/type/frequency/intensity/duratio n", and none of the non medication interventions listed on the relief of pain were completed. The form indicated the pain medication is effective, but the time elapsed until pain relief was not filled out and the conclusion portion of the assessment was not filled out. On 7/24/2017 at 9:53 a.m., - said she gets the routine medicine at breakfast and supper and sometimes asks for something in between, said it would be good if she just got the same thing routinely but she hasn't talked to anyone about it. A Policy and Procedure for "Pain Management" was provided by the		adjusted as needed. Completion Date: August 23, 2017	

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	Assistant Director of Nursing on 7/24/17 at 10:00 a.m. The policy indicated, but was not limited to: "Purpose: To ensure pain management by evaluating the resident for presence of pain, ensuring that appropriate medicine and/or treatment is given and that ongoing assessment for pain control is provided. Policy: It is the policy of this facility that residents will be properly assessed for the presence of acute or chronic pain, and if pain is present, it will be managed, treated and relieved...Procedure: 1. A pain assessment will be completed on any resident identified as having pain and residents with diagnosis that have pain as a common symptom. Appropriately authorized family members/friends may participate in the assessment. A standardized pain assessment instrument will be used. Assessing location, characteristics, onset, frequency, intensity, duration, precipitating factors and effectiveness of pain control measures...." B. 1. On 07/18/2017 at 2:12 p.m., Resident 95 was observed to have bruises across the the back of her left hand and bruises on her right hand and arm. Resident 95's record was reviewed on 7/21/2017 at 10:00 a.m. The record showed Resident 95 had diagnoses that			

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	included, but were not limited to, Alzheimer's disease, anxiety, depression, head injury, intracranial injury, psychosis, osteoarthritis, stage 3 kidney disease, and anemia. An Annual Minimum Data Set assessment, dated 4/29/17, indicated Resident 95 was severely cognitively impaired and indicated no skin conditions. On 7/21/2017 at 11:05 a.m., LPN 3 said it would be documented in the wound book if the resident was being followed for bruises, skin tears, or abrasions. She could not find anything in the wound book related to bruises. She said the residents will have a shower sheet filled out on their shower days that will have any skin problems observed and the CNAs would notify the nurse. A bath/shower sheet dated 7/14/17, indicated the resident had a bath/shower, her hair was washed, she was given nail care, and she had no skin problems. The shower sheet indicated: "...Please mark on the diagram below any skin problems you observe during bathing procedure. This form is to be given to the nurse in charge as soon as the bath is completed..."			

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	A bath/shower sheet dated 7/18/17, indicated the resident had a bath/shower, her hair was washed, she was not given nail care, and had no skin problems. On 7/21/2017 at 11:16 a.m., LPN 3 was observed as she measured the bruises on both of Resident 95's arms and her left hand. LPN 3 said Resident 95 has very fragile skin. The resident said "No" when LPN 3 asked if the bruises hurt, and shook her head "No" when asked if she knew how the bruises happened. Resident 95 had no care plan in place for at risk for bruising. B.2. Resident 134's record was reviewed on 7/20/17 at 10:47 a.m. Her diagnoses documented on her July 2017 physician's recapitulation orders included but were not limited to, respiratory failure, type 2 diabetes mellitus, and generalized muscle weakness. She would have a weekly skin sweep with new concerns documented on a progress note and the wound nurse notified. Resident 134's Quarterly MDS assessment dated 4/6/17, included she was understood and had the ability to understand others. She was moderately impaired in her daily decision making skills and had no skin areas of concern.			

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	A plan of care for Resident 134 initiated 2/1/17, included she was at risk for skin breakdown and other skin irritations related to decreased mobility. Her skin would be assessed daily with her bath. Her plan of care had not included any areas of discoloration or interventions for discolorations. A weekly skin sweep for Resident 134 documented on 7/6/17, 7/13/17, and 7/20/17, had not included any areas of skin discoloration. A shower sheet for Resident 134 documented on 7/18/17, included she had "no new areas @ this time." No areas of skin concern were marked on the anatomical figure. The facility was unable to provide any shower sheet documentation after 7/18/17. Point of Care documentation for Resident 134 on 7/19/17 at 1:59 p.m., 7/20/17 at 9;34 p.m., 7/21/17 at 8:38 a.m., and 7/22/17 at 7:05 p.m., included a "red area" that was not a new skin condition. The documentation had not included the location of the red area. On 7/19/17 at 11:21 a.m., Resident 134 was observed with a large purple area of discoloration on her left upper inner arm approximately the size of a half dollar			

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	and a smaller area of light purplish discoloration approximately the size of a dime on her left lower inner arm. Resident 134 voiced the areas of discoloration may have been caused by a blood pressure cuff or an insulin injection. On 7/20/17 at 12:02 p.m., Resident 134 was observed with the same purple area of discoloration on her left upper inner arm and the smaller area on her left lower inner arm was faded purplish color. She believed the areas of discoloration were caused by a blood pressure cuff. On 7/24/17 at 10:54 a.m., Wound Nurse 7 explained she was not aware Resident 134 had any areas of discoloration. The floor nurses conducted weekly skin sweeps and if there was an area of concern they documented how many areas on the resident's treatment sheet and filled out a skin sweep form which she reviewed and then assessed the resident. On 7/24/17 at 11:04 a.m., Wound Nurse 7 measured Resident 134's area of purple discoloration on her left inner upper arm, which measured 4 by 3 centimeters (cm). Wound Nurse 7 voiced the area looked new. Resident 134 informed Wound Nurse 7 she believed the area was caused by a blood pressure cuff.			

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	On 7/24/17 at 11:15 a.m., CNA 8 explained Resident 134 had a purplish area of discoloration with yellowish/greenish colors also when she had given a shower on 7/18/17. The area of discoloration had not looked new and Resident 134 had voiced to CNA 8 the area was not new. CNA 8 believed the area of discoloration was caused by a blood pressure cuff. On 7/24/17 at 12:50 p.m., Wound Nurse 7 explained she had spoken with CNA 9 who had cared for Resident 134 on 7/20/17. CNA 9 informed Wound Nurse 7 she had given Resident 134 a bed bath and had not filled out a shower sheet. CNA 9 had not seen any areas of skin discoloration. On 7/24/17 at 2:22 p.m., LPN explained she had seen bruising in the general in the area of Resident 134's arm area of discoloration. She believed the areas of discoloration were from a blood pressure cuff or getting Resident 134 up with the use of a mechanical lift. The "Guidelines for Bruising" provided by the Director of Nursing (DON) on 7/24/17 at 10:05 a.m., included the following: "1. You must fill out an Incident Report Form and follow all the			

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	Incident Instructions & Reporting guidelines, if injury is larger than 10 cm, or if the appropriate treatment requires an intervention by the M.D./wound nurse, notify DON. 2. For these small injuries you must do the following. 3. Provide the appropriate treatment from Standing Orders for Wound/Skin Care. 4. Make sure the injury and treatment/follow up is communicated to all involved staff (Point Click Care Message and 24 hour log, verbal report, and communication book, etc.). 6. Document injury & treatment/monitoring information in Point Click Care. Record on Skin Issue/Bruise Tracking Log and notify wound nurse so any patterns can be assessed & documented...." 3.1-37(a)			