STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345198	A. BUILDING _____ B. WING _____	05/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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
F 275 SS=D	483.20(b)(2)(iii) COMPREHENSIVE ASSESS AT LEAST EVERY 12 MONTHS (b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (iii) Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews the facility failed to complete an annual Minimum Data Set (MDS) assessment for 1 of 26 sampled residents in a timely manner. (Resident #87) The findings included: Resident #87 was admitted to the facility 04/08/16 with diagnoses which included Alzheimers. The admission MDS was dated 04/20/16. Subsequent quarterly MDS assessments for Resident #87 were dated 07/19/16, 10/18/16 and 01/16/17. Review of the electronic medical record of Resident #87 noted there were no MDS assessments completed after 01/16/17. On 05/10/17 at 11:30 AM MDS Coordinator #1 stated the assessment reference date for the annual MDS for Resident #87 was 04/18/17 and it was an oversight that the assessment was not completed. MDS Coordinator #1 stated it was her responsibility to complete the assessment and she had failed to complete the assessment in a timely manner.	F 275	Aston Park Health Care Center□s Response to this statement of Deficiencies and plan of correction Does not denote agreement with the statement of deficiencies not does it constitute an admission that any deficiency is accurate. Further, Aston Park Health care Center understands its right to refute any deficiency on this statement of deficiencies through informal dispute resolution, formal appeal and/or other administrative or legal procedures. Corrective Action: Some disciplines had completed their parts on resident #87's MDS Assessment, but it was not finished and submitted by the MDS Team. MDS Assessment for resident #87 was completed and submitted by MDS Coordinator #1 on 5-10-17 and locked and submitted on 5-19-17. All MDS/Care plan staff was retrained by RN/Case Mgr and Director of Social Services on 5-12-2017 on	6/9/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/01/2017

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F 275	Continued From page 1 On 05/12/17 at 1:40 PM the Administrator and Director of Nursing stated they expected MDS assessments to be completed by the due date.	F 275	submitting MDS assessments for residents timely using the Scheduler within the EHR and the backup manual calendar that is kept to alert staff of due dates for the MDS Assessment completions. MDS/Care plan team was also counseled on following these processes and not checking them off until completed and submitted on 5-12-17. Corrective Action for Potential Deficient Practice: An audit of all facility MDS assessments was conducted by RN/Case Manager and Director of Social Services on 5-10-17 to assure that no other MDS assessments had not been completed and submitted per schedule. Systematic Changes: In addition to retraining staff on timely and accurate completion and submission of MDS Assessments on 5-12-17, Another step was added in the EHR process for MDS Assessments by the DON on 5/23/17 to check off when the Assessment is submitted. This will alert staff that the submission process has not been completed until it is checked off. An audit of all MDS Assessments will be completed by the RN/Case Mgr weekly starting 6-1-17 for 3 months and then randomly thereafter to assure that all MDS Assessments due during that time period are submitted timely. Monitor Plan of Facility:	

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F 275	Continued From page 2	F 275	The RN/Case Manager or designee will complete a compliance audit once a week for 3 months and randomly thereafter for submitting MDS Assessments timely. Results of the audits will be reviewed and evaluated by the Facility's Quality Assurance and Performance Improvement Committee for a 3-month period and if the issue appears resolved, will review randomly by Staff Development Coordinator or designee thereafter to assure compliance.	
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money	F 278		6/9/17

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F 278	Continued From page 3 penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) for 1 of 1 resident (Resident #19) reviewed with a Level II Preadmission Screening and Resident Review (PASRR). Findings included: Resident #19 was admitted on 10/27/16 with diagnoses that included brief psychotic disorder, paranoid schizophrenia and anxiety disorder. The admission MDS assessment dated 11/10/16 indicated Resident #19 had not been evaluated by level II PASRR and determined to have a serious mental illness, intellectual disability and/or related condition. A review of Resident #19's medical record revealed a North Carolina Medicaid Uniform Screening Tool (NC MUST) printout that included the level II PASRR number with an expiration date of 11/14/16. The PASRR number contained the letter "F" which indicated authorization for a 30 to 60 day limited stay, level II reviews only. During an interview on 5/12/17 at 4:20 PM MDS	F 278	Corrective Action: MDS Assessment for resident #19 was corrected and resubmitted on 5-10-17. All MDS/Care plan staff was retrained on how to access the PASRR in the EHR and the differences between Levels I & II, so that the MDS Assessment can be coded accurately by the RN/Case Manager and Director of Social Services on 5-12-17. Corrective Action for Potential Deficient Practice: An audit of all facility MDS assessments was conducted by the Director of Social Services to assure that no other MDS assessments for residents with PASRR Level II were coded incorrectly on 5-12-17. Systematic Changes: In addition to RN/Case Mgr and Director of Social Services retraining staff on timely and accurate completion and submission of MDS Assessments on	

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F 278	Continued From page 4 Coordinator #1 confirmed she had reviewed the NC MUST printout for Resident #19 prior to completing the admission MDS assessment dated 11/10/16. She added she had coded the level II PASRR section as "no" because she had not realized Resident #19's number indicated a level II PASRR. The MDS Coordinator #1 acknowledged Resident #19's MDS dated 11/10/16 had been inaccurately coded and a modification would need to be submitted. During an interview on 5/12/17 at 5:03 PM the Administrator stated Resident #19's PASRR confirmation was obtained prior to admission and later scanned into the resident's electronic medical record for staff access. The Administrator confirmed Resident #19 had a Level II PASRR and if unsure, the MDS Coordinator should have asked for clarification. The Administrator stated it was her expectation for the MDS assessments to be accurately coded.	F 278	5-12-17, another step was added in the EHR process by the DON for MDS Assessment completion on 5-24-17 to check the PASRR prior to locking and submitting. This will alert staff to check the level of the PASRR prior to submission of MDS Assessment for accuracy. Monitor Plan of Facility: The Staff Development Coordinator or designee will complete a compliance audit once a week for 3 months and randomly thereafter for coding MDS Assessments accurately. Results of the audits will be reviewed and evaluated by the Facility's Quality Assurance and Performance Improvement Committee for a 3-month period and then randomly by SDC thereafter to assure compliance.	
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility failed to provide assistance with shaving, grooming and nail care for 2 of 4 residents reviewed who required extensive to total assistance with activities of daily living (Resident #82 and #153).	F 312	Corrective Action: Facial hair on resident #82 was removed on 5-11-17 by the 3-11 NA. The nurse supervisor coaxed resident #153 to allow 3-11 NA to cut fingernails, shave and shower him on 5-11-17.. Glasses were cleaned as well.	6/9/17

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F 312	Continued From page 5 Findings included: 1. Resident #82 was admitted on 03/04/15 with diagnoses that included Alzheimer's disease, dementia and cerebrovascular disease (stroke). The annual Minimum Data Set (MDS) dated 02/08/17 coded Resident #82 with severe, cognitive impairment for daily decision making. The MDS indicated Resident #82 required extensive to total staff assistance with all activities of daily living (ADL). Review of Resident #82's ADL care plan, with an onset problem date of 03/26/15, revealed a self-care deficit due to Alzheimer's dementia and inability to communicate needs. A goal listed was for her to be well-groomed and appropriately dressed daily. Interventions included for staff to provide extensive to total assistance with adl. Review of Resident #82's Resident Profile revealed showers were scheduled for Tuesday, Thursday and Saturday between 7:00 AM and 3:00 PM. An observation of Resident #82 on 05/08/17 at 3:28 PM revealed her sitting out in the hallway with several noticeable chin hairs approximately a half inch long. An observation of Resident #82 on 05/09/17 at 10:33 AM revealed her sitting out in the hallway with several noticeable chin hairs approximately a half inch long. An observation of Resident #82 on 05/10/17 at 4:30 PM revealed her sitting out in the hallway with several noticeable chin hairs approximately a	F 312	CNA's were in-serviced by Staff Dev. Coord. May 26, 2017 on procedures for ADL care including checking for and removing any visible facial hair and clipping fingernails if needed on shower days. Also, they were counseled on the importance of keeping residents' eye glasses cleaned and notifying the charge nurse or supervisor when any resident refuses ADL care. Corrective Action for Potential Deficient Practice: All residents were checked to make sure there was no visible facial hair, nails were clean and clipped appropriately and eyeglasses were clean on the evening of May 11, 2017 by the DON and ADON. Systematic Changes: In addition to retraining staff on the importance of removing facial hair, checking and performing nail care as needed, keeping eye glasses clean and notifying supervisor when a resident is refusing ADL care, added documentation buttons were added to the ADL Kiosk documentation system by DON to allow for staff to check for these items each shift and document results. Monitor Plan of Facility: The Staff Development Coordinator or designee will complete a compliance audit once a week starting 5-13-17 for 3 months and randomly thereafter for giving proper ADL care to include, removal of facial hair, cleaning and clipping nails,	

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F 312	Continued From page 6 half inch long. An observation of Resident #82 on 05/11/17 at 10:58 AM revealed her sitting out in the hallway, dressed in clean clothing with slightly damp hair and several noticeable chin hairs approximately a half inch long. Resident #82 was unable to be interviewed due to her severe dementia and inability to participate in conversation. Resident #82's Responsible Party was unable to be reached for a phone interview. During an interview on 05/11/17 at 11:05 AM Nurse Aide (NA) #1 confirmed she had given Resident #82 a shower that morning. NA #1 added she had not noticed her with any chin hair and had never shaved Resident #82 when providing personal hygiene care. NA #1 explained when a resident needed a shave she checked with the nurse to make sure the family had not specified other preferences. NA #1 confirmed Resident #82 had several long chin hairs that needed shaved and stated she should have checked with the nurse when she had given her a shower. During an interview on 05/11/17 at 11:36 AM Nurse #1 stated personal hygiene care was part of the bathing routine and if needed, residents should be shaved when receiving a shower unless it was specified otherwise in their care plan. Nurse #1 confirmed Resident #82 had several long chin hairs that should have been shaved when she had received a shower that morning. Nurse #1 indicated she would instruct the NA to shave Resident #82. During an interview on 05/12/17 at 10:14 AM the	F 312	keeping resident eye glasses clean and notifying supervisor of any residents who are refusing ADL care. Results of the audits will be reviewed and evaluated by the Facility's Quality Assurance and Performance Improvement Committee for a 3-month period and then randomly by SDC thereafter to assure compliance.	

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F 312	Continued From page 7	F 312		

Director of Nursing (DON) confirmed it was her expectation staff would provide residents with personal hygiene care when needed.
2. Resident #153 was admitted to the facility on 02/27/17 with diagnoses including diabetes, glaucoma, and anxiety among others. The admission Minimum Data Set (MDS) dated for 03/10/17 indicated Resident #153 had mild cognitive impairment and often felt tired or had little energy. The MDS also indicated Resident #153 required extensive assistance with hygiene. Review of the care plans indicated Resident #153 required extensive assistance with most of his activities of daily living, including hygiene.

During an observation on 05/09/17 at 10:33 AM, Resident #153 was noted to have fingernails on both hands over a quarter an inch long, stubble on his cheeks, upper lip, and chin, and was wearing glasses that were smudged with a greasy type coating on both lenses.

During an observation on 05/10/17 at 2:50 PM, Resident #153 was in his room visiting with his wife. Resident #153 was noted to be unshaven, had long fingernails on both hands, and had glasses on with a greasy coating on both lenses.

During an observation on 05/11/17 at 2:35 PM, Resident #153 was in his room visiting with his wife. Resident #153 was noted to be unshaven, had long fingernails on both hands, and had glasses on with a greasy coating on both lenses.

During an interview on 05/11/17 at 2:56 PM, Nurse #2 stated there were several ways a nurse aide (NA) knew what to do for the residents. Nurse #2 stated there was an assignment book on each hall that the NAs reviewed to know who

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F 312	Continued From page 8	F 312		

was on the shower list for the day. Nurse #2 also stated on the residents shower days the bed linens were changed and the residents would be shampooed and shaved unless they were on a list not to have this done. Nurse #2 further stated the NAs should be doing nail care whenever it was needed, but there was not an official protocol for when or how often it was done. Nurse #2 also stated the NAs could also look at the resident profile information to know what needed to be done for a resident and the NAs all were given report from the NAs going off duty.

During an interview on 05/11/17 at 4:08 PM, Resident #153 stated he had not been shaved in about a week and a half. Resident #153 further stated he was not able to cut his fingernails very well since he had a stroke and no longer had good strength in his hands anymore. Resident #153 also stated he tried to clean his glasses in the morning before putting them on but this was also difficult because of the weakness in his hands.

During an interview on 05/11/17 at 4:20 PM, the Director of Nursing (DON) observed Resident #153 in his room. The DON acknowledged Resident #153's nails were too long and needed to be cut. The DON stated she would arrange for the treatment nurse to put this on the schedule to be done regularly. Resident #153 stated he would like to be shaved during his shower but this had not been done in about a week and a half so he had not been shaved. The DON also observed the glasses for Resident #153 were dirty and stated they should be cleaned as often as necessary, then asked for his glasses, cleaned them and then returned his glasses to him.

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F 312	Continued From page 9	F 312		

During an observation on 05/12/17 at 8:15 AM, Resident #153 was noted to be clean shaven, had on clean glasses and his fingernails were cut.

During an interview on 05/12/17 at 12:53 PM, NA #3 stated although he had worked with Resident #153 during the week, he had not noticed whether his nails were cut, his glasses were clean, or if he had been shaved. NA #3 stated Resident #153 had a tendency to refuse showers and that was when Resident #153 would be shaved. NA #3 acknowledged Resident #153 had never refused a shave when it had been offered to him. NA #3 stated he cleaned residents nails as needed but did not cut nails since that was a task for the restorative aides to do.

During an interview on 05/12/17 at 1:53 PM, NA #4 stated Resident #153 put his glasses on independently and she had not seen that his glasses were dirty and had not offered to clean them during the week. NA #4 also stated they did resident nail care on shower days or when needed. NA #4 further stated she offered to cut Resident #153's nails and shave him twice during the current week but he refused. NA #4 stated that she had not reported to the nurse Resident #153 had refused for his nails to be cut or that he refused to be shaved.

Review of nurse's notes on 05/12/17 at 3:49 PM revealed there was no documentation of refusal of care indicated between 05/08/17 and 05/11/17 for Resident #153 with the exception of refusing to be weighed on 05/10/17.
During an interview on 05/12/17 at 4:00 PM, Resident #153 stated he had received "a great

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F 312	Continued From page 10 shower, shave, nails cut, glasses clean" the previous evening and he was happy. Review of the resident profile information on 05/12/17 at 4:20 PM indicated Resident #153 was supposed to have a shower on Mondays, Wednesdays and Fridays on 2nd shift (3 PM - 11 PM). The resident profile information had no information listed under a section titled "Vision" and no directions for how often Resident #153 was to be shaved, have his nails cut, or his glasses cleaned. During an interview on 05/12/17 at 5:07 PM, the DON stated her expectations were for the NAs to offer care multiple times if a resident refused. The DON also stated if the resident continued to refuse, another care giver should be asked to try and assist the resident and the nurse needed to be involved. The DON further explained the nurse needed to be involved to determine if refusals were problematic and if so, to notify the physician if the resident needed to be seen by another provider (i.e. psychiatric services or Veteran's Administration services). The DON further stated her expectations were for the NA's to tell the nurses if care was refused.	F 312		
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete;	F 514		6/9/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 514	Continued From page 11 (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interview the facility failed to correctly document the skin condition for 1 of 5 residents (Resident #168) reviewed for body audits. The findings included: Resident #168 was admitted to the facility on 05/03/17 with diagnoses which included heart failure, high blood pressure, malnutrition and non-Alzheimer's dementia. The admission Minimum Data Set (MDS) dated 05/10/17 had not	F 514	Corrective Action: A complete body audit/skin assessment was completed by the charge nurse and another RN for Resident #168 and signed by the charge nurse on 5-11-17 on a paper skin assessment/body audit form that allows for more detailed descriptions, drawings of exact location and sizes as opposed to the EHR version of the body audit. Follow-up with physician to verify that ecchymosis was present on admission and evolving as expected	

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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
F 514	Continued From page 12 been fully completed at the time of this investigation. The MDS noted Resident #168 required extensive assistance for bed mobility and transfers. Review of discharge records from the hospital indicated Resident #168 was admitted to the hospital from home after "multiple falls that resulted in acute T10 (thoracic vertebrae #10 in central back) compression fracture and pelvic fracture." Resident #168 was also noted to have "healing right rib fractures." Resident #168 was on an anticoagulant (helps prevent blood from clotting) when he entered the hospital. Resident #168 had blood work at the hospital on the day of his admission (04/28/17) indicating his Prothrombin Time (PT - time it takes for blood to clot with normal of 10 to 14 seconds) of 27.1 seconds. Due to the frequent falls Resident #168 was having, he was considered to be a poor candidate for continuation of the anticoagulant and it was discontinued prior to his discharge from the hospital to the facility on 05/03/17. Review of the initial body audit completed at the facility on 05/03/17 at 6:40 PM indicated Resident #168 had the following areas of ecchymosis (bruising): right upper chest 5 centimeters (cm) x 4 cm and right lower back 25 cm x 15 cm. Further body audits indicated the following: 05/04/17 at 3:43 AM - no mention of ecchymosis on chest or back 05/05/17 at 11:32 AM - ecchymosis right upper chest 5 cm x 4 cm and right lower back 25 cm x 15 cm 05/05/17 at 11:40 PM - no mention of ecchymosis on chest or back	F 514	considering injuries prior to hospitalization and admission to Facility. Corrective Action for Potential Deficient Practice: All nurses were retrained in procedures for body audits/skin assessments on proper descriptive notes, drawings and measurements of all areas and importance of a thorough exam for each audit by the Staff Development Coordinator on May 31, 2017. All skin/body assessments are done weekly on each resident. The new system was used for all weekly body/skin assessments done during the week of May 15, 2017 and forward. Systematic Changes: In addition to retraining all nurses in accurately completing body audits/skin assessments, system for body audits/skin assessments was changed back to paper documents on 5-11-17, in order to allow for more descriptive drawings and measurements. Notebooks were placed on each hall for the skin and body audits. As they are completed, they will be scanned into the resident□s EHR by medical records. System change was started as of 5-11-17 and used going forward. Monitor Plan of Facility: The Staff Development Coordinator or designee will complete a compliance audit once a week for 3 months and randomly thereafter for continued compliance in	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345198	A. BUILDING _____ B. WING _____	05/12/2017

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F 514	Continued From page 13 05/06/17 at 11:09 AM - ecchymosis right upper chest 5 cm x 4 cm and right lower back 25 cm x 15 cm 05/07/17 at 11:12 AM - ecchymosis right upper chest 5 cm x 4 cm and right lower back 25 cm x 15 cm 05/07/17 at 11:00 PM - no mention of ecchymosis on chest or back 05/08/17 at 10:32 AM - ecchymosis right upper chest 5 cm x 4 cm and right lower back 25 cm x 15 cm 05/08/17 at 11:00 PM - no mention of ecchymosis on chest or back 05/09/17 at 4:19 AM - ecchymosis to right upper chest and right lower back in various stages of healing 05/10/17 at 12:27 AM - no mention of ecchymosis on chest or back During an observation of the placement of a pain relieving patch to the back during medication administration on 05/11/17 at 8:10 AM, Resident #168 was noted to have significant ecchymosis from his middle to lower back - right side, ecchymosis 4 inches below his right axillary (armpit) to 4 inches above his right hip, and ecchymosis from just below his central chest down toward his lower abdomen on his right side. After the discrepancy in body audit information was shared with the Director of Nursing (DON,) a skin assessment form was completed on 05/11/17 which indicated ecchymosis 45 cm x 21 cm to his right lower back and distributed across his right side and right upper chest. During an interview on 05/11/17 at 5:45 PM, the Nurse Aide (NA) #2 stated she was present when Resident #168 was admitted to the facility from	F 514	accurate body audits/skin assessments. Results of the audits will be reviewed and evaluated by the Facility□s Quality Assurance and Performance Improvement Committee for a 3-month period and then randomly by SDC thereafter to assure compliance.	

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F 514	Continued From page 14	F 514		

the hospital. NA #2 stated Resident #168 had extensive bruising below the nipple line on his right side, under his right arm and on his back. NA #2 further stated the area was pinkish when she first saw but was now darker but it appeared to be the same size to her.

During an interview on 05/12/17 at 9:08 AM, the DON stated Resident #168 had been on an anticoagulant for a long time before coming to the facility. The DON further acknowledged the computer grid scale the facility used for documenting skin issues was not completely accurate.

During an interview on 05/12/17 at 10:09 AM, the Assistant Director of Nursing (ADON) stated she followed up on new residents the day of their admission or the day after. The ADON stated she saw Resident #168 on 05/04/17 and noted he had thoracic bruising and multiple bruises on both arms.

During an interview on 05/12/17 at 5:02 PM, the DON stated she expected her staff to document exactly what they saw to the best of their ability when assessing a resident. After review of the body audits for 05/04/17 through 05/10/17, the DON acknowledged the documentation did not accurately reflect the skin condition for Resident #168. The DON also stated she felt some of this was due to an electronic documentation system that did not allow for a clear picture of what the body actually looked like due to a graph system. The DON further stated they would be going back to a paper body audits for charting that would be scanned into the computer for better accuracy of describing skin conditions.