STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **185089**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **09/23/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTHCARE OF BOWLING GREEN	**550 HIGH ST. BOWLING GREEN, KY 42101**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0157 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor and a family member of the resident of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and review of facility's policy it was determined the facility failed to notify the physician of a significant change in condition for one (1) of five (5) sampled residents (Resident #3). Resident #3's abdominal wound began to have increased drainage and odor and the facility failed to notify the physician. The findings include: Review of the facility's policy titled, Change in a Resident's Condition or Status, last revised February 2014, revealed our facility shall promptly notify the resident, his or her attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.). The Nurse Supervisor/Charge Nurse will notify the resident's attending Physician or on-Call physician when there has been: A significant change in the resident's physical/emotional/mental condition. A 'significant change' of condition is a decline or improvement in the resident's status that: Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical intervention (is not self-limiting); impacts more than one area of the resident's health status; requires interdisciplinary review and/or revision to the care plan, the nurse supervisor/charge nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. Record review revealed the facility admitted Resident #3 on 08/15/14 with [DIAGNOSES REDACTED]. Review of the Initial Minimum Data Set (MDS) Assessment, dated 08/22/14, revealed the facility assessed the resident's cognition as moderately impaired with a Brief Interview for Mental Status (BIMS) score of ten (10) which indicated the resident was interviewable. Review of the physician's orders [REDACTED]. Review of the Nurse's Notes revealed on 08/23/14 (no time) the resident's wound dressing changed, scant to moderate amount of drainage (brownish) present; complains of abdominal pain; seems to think (he/she) has another abscess on right side; hurts to lay on that side; on 08/28/14 (no time), there was a large amount drainage with odor noted; on 08/30/14, (no time) the abdominal dressing changed red-bloody drainage to drain sponge and abdomen pad, moderate amount, odorous. There was no documented evidence the physician was notified of the increased drainage, increased dressing changes or odor. Review of a Nurse's Note, dated 08/31/14 (no time) revealed the resident complains of pain at abdominal site and to right of incision, states he/she feels like something is pulling when he/she moves. Further review revealed the Evening Nurse noted, States (he/she) hurts so bad (he/she) wants to go to ER (emergency room). There was no documented evidence the physician was notified. Review of a Situation, Background, Assessment, Request (SBAR) Communication Form, dated 09/01/14 at 9:00 AM, revealed the resident complains of increased pain to abdomen. In the Nursing Notes portion of the SBAR Communication Form it was noted the facility called the physician concerning the need to increase as needed pain medication frequency because of pain. Further review revealed the request was to change the [MEDICATION NAME] order from every four (4) hours as needed to [MEDICATION NAME] every three (3) hours as needed. The Communication Form indicated the facility had received orders for [MEDICATION NAME] to be increased; and, the family and physician were notified. However, there was no documented evidence the physician was made aware of the increased drainage and odor. Review of a Nurse's Notes revealed on 09/07/14 (no time) the resident's abdomen continued to be sore on right side and continued to have moderate to severe amount of bloody drainage, dressing changed; strong odor detected; (no time). On 09/07/14, the same nurse on another shift noted, Resident post antibiotic therapy for abdominal wound; drainage and odor remain, changed dressing every shift; complains of pain to abdominal site and right side; and, on 09/09/14 (no time), a Nurse's Note revealed there was a Large amount of serosanguinous drainage noted. Further review revealed there was no documented evidence the physician was notified of the increased drainage and odor. Review of Resident #3's August and September 2014 Treatment Administration Record (TAR) revealed there was no documented evidence of any additional wound dressing treatments administered besides the physician ordered twice daily treatments. Observation, on 09/17/14 at 8:07 AM, revealed near Resident #3's room in the hallway there was a pungent odor, resident was at the side of bed eating breakfast off of tray on bedside table facing the door; the room had the same pungent smell as the odor in the hallway but was stronger. On the floor at the end of the resident's bed were three non-dried red colored spots on the floor. Interview with Resident #3, on 09/17/14 at 8:07 AM, revealed the red stains were bloody drainage that had leaked out of his/her dressing when he/she had gotten up to use the bathroom. The resident stated he/she was receiving three (3) to four (4) dressing changes a day due to more drainage from his/her abdominal wound. The resident revealed the drainage had increased, was more excessive when ambulatory and during a regular day he/she would ask a nurse to change his/her dressing because of the amount of drainage. Interview with Certified Nursing Assistant (CNA) #2 , on 09/23/14 at 4:00 PM, revealed Resident #3's room has a bad odor, and when she gave him/her a shower his/her wound had a bad smell. She further stated she did not know if the smell had worsened as she was new to the hall and the smell had been consistently strong since she had been on that side. Interview with Licensed Practical Nurse (LPN) #2, on 09/23/14 at 4:17 PM, revealed she noticed the odor in Resident #3's room and she described it as a foul odor related to Resident #3's wound. She further stated she did not know the time frame of the smell worsening. She stated the abdominal surgical wound had the same foul odor since she had been moved to care for residents on that hall. Interview with Registered Nurse (RN) #1, on 09/23/14 at 4:20 PM, revealed Resident #3 had an odor to his/her abdominal wound and the wound smelled like stinky feet. She stated she thought it was his/her feet smelling bad; however, when she changed the dressing to his/her abdominal wound she realized the stinky foot smell was a bad smell that came from his/her abdominal wound. RN #1 stated the odor has been there since the resident was admitted . Further interview with RN #1, on 09/17/14 at 5:01 PM, revealed she provided care to Resident #3 and had changed the dressing more than ordered because of the dressing being saturated. RN #1 further revealed she knew the order was for twice a day, but if the dressing was dirty you would change it no matter what. She stated if the dressing becomes saturated, especially if Resident #3 is up and ambulating the dressing would have to be changed. Interview, on 09/18/14 at 8:26 AM with LPN #3, revealed she usually did three (3) dressing changes for Resident #3 because of drainage. LPN #3 stated dressings were supposed to be done every shift, and she knew she had to do it more than once a shift because of drainage. LPN #3 further revealed she had not spoken with the physician related to dressing changes, she just did what the computer told her to do related to the treatment, and it says every shift and has since resident has been here. Interview, on 09/18/14 at 10:48 AM with RN #2, revealed she was not assigned to change Resident #3's dressing but would if it was soiled or asked to by the resident. RN #2 could not recall orders for the resident and had not called the physician about changing the dressings but had passed the information to the oncoming shift. Interview, on 9/18/14 at 10:17 AM with Resident #3's Physician, revealed he would have expected to be notified if the resident was having additional dressing changes related to increased drainage.

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185089	A. BUILDING ______ B. WING _____	**09/23/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTHCARE OF BOWLING GREEN	**550 HIGH ST. BOWLING GREEN, KY 42101**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0157 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1)
F 0282 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide care by qualified persons according to each resident's written plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and review of the facility's policy and procedure it was determined the facility failed to provide services in accordance with the care plans for two (2) of five (5) sampled residents (Resident #1 and Resident #5). Resident #1 was care planned for staff to report changes in the resident's skin status and administer medications as ordered due to a tumor to the resident's right hand. However, the facility failed to monitor the wound to identify any changes and failed to administer treatment to the wound as ordered. Maggots were identified in the wound on 09/05/14. In addition, Resident #5's heels were not floated according to the resident's care plan. The findings include: Record review revealed the facility admitted Resident #1 on 08/02/13 with [DIAGNOSES REDACTED]. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 08/20/14, revealed the facility assessed Resident #3's cognition as severely impaired with a Brief Interview of Mental Status score of 3; and, the resident required extensive assistance with activities of daily living. Review of the Comprehensive Care Plan, Resident has actual skin breakdown, dated 08/21/14, revealed the resident had a right hand tumor and interventions included for staff to report changes in the resident's skin status (i.e.: s/s of infection, non-healing, new areas) to physician. Review of the Non-pressure Skin Condition Record Assessments revealed the date the wound was first observed was on 12/18/13. The wound was on the back of the resident's right hand and was described as a growth. Further review of the Non-pressure Skin Condition Record Assessments revealed the wound was measured and described on 05/12/14, as 7.1 cm x 7.0 cm with a small amount of serosanguineous drainage, no change; on 05/19/14 as 7.0 cm x 7.2 cm with small amount of serosanguineous drainage, no change; on 05/26/14 as 7.0 cm x 7.0 cm, no drainage, no change; on 06/02/14 as 7.0 cm x 7.1 cm with small amount of serosanguineous drainage, no change; and, on 06/09/14 as 7.0 x 6.9 with foul odor and serosanguineous drainage, no change. There was no documented evidence any further wound assessments were completed of the wound until 09/12/14 when the wound measured 12.5 x 15.8 x 2.5 cm and bloody drainage was noted. Interview on 09/16/14 at 8:08 AM; and, on 09/17/14 at 10:44 AM with Assistant Director of Nursing (ADON) #1, revealed the resident's right hand tumor was measured up until 06/09/14, but was not measured after that time. She stated the measurements were started back up on 09/12/14 because the new DON wanted staff to measure the resident's right hand. The ADON revealed it was her responsibility to make sure that the Non-pressure Skin Condition Records were completed, but the previous DON did not want to measure areas like Resident #1's right hand, and further stated if they thought it did not need to be done we did not do it. Interview, on 09/17/14 at 5:16 PM with Registered Nurse (RN) #2, revealed maggots were found in the wound of Resident #1's right hand between 11:30 PM and 1:00 AM on 09/05/14. Interview, on 09/16/14 at 10:03 PM with Licensed Practical Nurse (LPN) #4, revealed maggots were found on the dressing of the resident's right hand and in the wound on his/her right hand on 09/05/14. Review of the Comprehensive Care Plan for Infection, dated 09/05/14, revealed the resident had active infection in his/her wound. Interventions included to administer medications as ordered and assess the wound bed during dressing changes for any additional abnormalities. Review of a telephone Physician Order, dated 09/05/14, revealed to discontinue order to cleanse right hand with normal saline, apply dry dressing wrap with kerlix twice a day; and, a new order to cleanse the resident's right hand growth with normal saline, apply dry dressing then wrap with kerlix every shift. Review of the September 2014 Treatment Administration Record (TAR) revealed the new order received on 09/05/14, for treatment every shift was not placed on the TAR until 09/10/14. Record review revealed no documented evidence Resident #1 received the treatments to his/her right hand wound every shift from 09/05/14 through 09/10/14; and, on 09/12/14, and 09/15/14. Interview on 09/18/14 at 9:24 AM and 3:19 PM with the Assistant Director of Nursing (ADON) #1 revealed she had taken the order on 09/05/14 for Resident #1 to change the treatment for [REDACTED]. She stated the order would have to be put in the computer system to ensure it was printed on the TAR. She was unable to give an explanation as to why the order was not on the TAR prior to 09/10/14. Interview on 09/17/14 at 9:20 AM with the Director of Nursing, revealed the ADONs were supposed to measure pressure and non-pressure wounds. The DON further stated she instructed staff that anything on the non- pressure sheet should have had a measurement to it, and the ADONs were aware they were supposed to measure the pressure and non-pressure areas, and care plans should be specific to the resident. Interview, on 09/18/14 at 7:53 AM and 2:02 PM with Resident #1's Physician revealed he did not expect maggots to be in residents' wound and if dressings were not changed they could get dirty and infected. 2. Record review revealed Resident #5 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Admission MDS assessment, dated 08/18/14, revealed the facility assessed Resident #5's cognition as cognitively intact with a BIMS score of fifteen (15) which indicated the resident was interviewable. Resident #5 required the extensive assistance with activities of daily living. Review of the Interim Care Plan for Actual Alteration in Skin Integrity, dated 09/10/14, revealed an intervention to use heel floating devices. Observation, on 09/19/14 at 8:20 AM, 8:57 AM, and 11:00 AM revealed Resident #5's feet were uncovered and not elevated. Interview on 09/18/14 with LPN #1 at 11:00 AM and LPN #2 at 10:58 AM, revealed the care plans were for staff to know how to take care of the resident and were to be specific to the resident. Interview with ADON #1, on 09/22/18 at 11:08 AM, revealed staff used pillows and blankets to elevate Resident #5's feet. Interview on 10/01/14 at 3:50 PM and 4:08 PM with the DON revealed she did not have a care plan policy that addressed following the care plan.

F 0309 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide necessary care and services to maintain the highest well being of each resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, facility policy and procedure review, and Hospital Admission Record review it was determined the facility failed to provide services to maintain/attain the highest practicable physical, mental and psychosocial well-being for two (2) of five (5) sampled residents (Resident #1 and Resident #3). Resident #1's was identified with a cyst to the back of the right hand on admission on 12/18/13. Staff completed wound assessments on the wound through 06/09/14 when the wound measured 7.0 centimeters (cm) x 6.9 cm. and was identified as having a foul odor and serosanguineous drainage. There was no documented evidence of further wound assessments until maggots were identified in the wound on 09/05/14. A physician's orders [REDACTED]. A wound assessment was completed on 09/12/14 with the wound measuring 12.5 cm x 15.8 cm x 2.5 cm and bloody drainage was noted. In addition, Resident #3's abdominal wound began to have increased drainage and odor and the facility failed to notify the physician to determine if additional treatment was necessary. The findings include: Review of the facility's policy titled, Skin Management and Prevention At-A-Glance, last revised August 2013, revealed the Weekly Skin Rounds Sheet would be utilized to determine if any new skin alterations had developed. Clinical nurses, or nurse designee, on the unit were responsible for the weekly completion of these Sheets. It is the responsibility of the clinical team (DON, ADON, Nurse Managers) to determine compliance. Any new skin condition(s) found during the weekly skin rounds will be documented in the appropriate form (Pressure or Non-pressure, and Skin Ulcer Change of Condition Evaluation if appropriate). Responsible party for completing this form is the nurse who finds the skin alteration. Documentation of new sites must have physician and family notification with documentation of this communication with the medical record. The responsible party for completing this form is the nurse finding the skin alteration. Record review revealed the facility admitted Resident #1 on 08/02/13 with [DIAGNOSES REDACTED]. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 08/20/14, revealed the facility assessed Resident #3's cognition as severely impaired with a Brief Interview of Mental Status score of three (3); Resident #1 required extensive assistance with activities of daily living. Review of the Comprehensive Care Plan for Actual Skin Breakdown, dated 08/21/14 due to a right hand tumor; with a goal, dated 11/19/14, stating resident will have intact skin, free of redness, blisters, or discoloration over a bony prominence through next review date. Review of the interventions revealed to report changes in skin status (i.e.: s/s of infection, non-healing, new areas) to physician, complete weekly skin check, notify nurse immediately of any new areas of skin breakdown, redness, blisters, bruises, discoloration noted during bathing or daily care. There were no interventions to address the right hand tumor on the resident's hand. Review of Physician Order, dated 08/28/14, revealed to cleanse right hand growth (tumor) with normal saline, apply dry dressing, wrap with kerlix twice daily with [DIAGNOSES REDACTED]. Review of the Non-pressure Skin Condition Record Assessments revealed the date the wound was first observed was on 12/18/13 The wound was on the back of the resident's right hand and was described as a growth. Further review of the Non-pressure Skin Condition Record Assessments revealed the wound was measured and described on 05/12/14, as 7.1 cm x 7.0 cm with a small amount of serosanguineous drainage, no change; on 05/19/14 as 7.0 cm x 7.2 cm with a small amount of serosanguineous drainage, no change; on 05/26/14 as 7.0 cm x 7.0 cm, no drainage, no change; on 06/02/14 as 7.0 cm x 7.1 cm with small amount of serosanguineous drainage, no change; and, on 06/09/14 as 7.0 x 6.9 with a foul odor and serosanguineous drainage, no change. There was no documented evidence any further wound assessments were completed until 09/12/14 when the wound measured 12.5 x 15.8 x 2.5 cm and bloody drainage was noted. Interview on 09/16/14 at 8:08 AM; and, on 09/17/14 at 10:44 AM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185089	A. BUILDING ______ B. WING _____	**09/23/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTHCARE OF BOWLING GREEN	**550 HIGH ST. BOWLING GREEN, KY 42101**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 0309

Level of harm - Actual harm

Residents Affected - Few

(continued... from page 2)
with the Assistant Director of Nursing (ADON) #1, revealed the right hand tumor was measured up until 06/09/14 but it was not measured after that time. ADON #1 further stated the measurements were started back up on 09/12/14 because the new DON wanted staff to measure the resident's right hand. The ADON revealed it was her responsibility to make sure that non-pressure skin condition records were completed, but the previous DON did not want to measure areas like Resident #1's right hand. ADON #1 further stated if the DON did not want the non pressure wounds measured then we did not do it. Interview, on 09/17/14 at 5:16 PM with Registered Nurse (RN) #2, revealed maggots were found in the wound of Resident #1's right hand between 11:30 PM and 1:00 AM on 09/05/14. Interview, on 09/16/14 at 10:03 PM with Licensed Practical Nurse (LPN) #4, revealed maggots were found on the dressing on the resident's right hand and in the wound of Resident #1's right hand on 09/05/14. Further interview revealed the treatment for [REDACTED]. Review of Telephone Physician Order, and Nursing Notes, dated 09/05/14, revealed Resident #1 was sent to the emergency room for wound determination to the right hand, and returned on 09/05/14 with an order for [REDACTED]. Review of the Comprehensive Care Plan for Infection, dated 09/05/14, revealed the resident had active infection in wound with interventions to administer medications as ordered and assess wound bed during dressing changes for any additional abnormalities. Review of Telephone Physician Order, dated 09/05/14, revealed to discontinue order to cleanse right hand with normal saline, apply dry dressing wrap with kerlix twice a day; and a new order to cleanse right hand growth with normal saline, apply dry dressing then wrap with kerlix every shift. However, review of the September 2014 Treatment Administration Record (TAR) revealed the new order for treatment every shift was not placed on the TAR until 09/10/14 and there was no documented evidence Resident #1 received the treatments to the right hand wound every shift from 09/05/14 through 09/10/14, on 09/12/14, and on 09/15/14. Interview on 09/18/14 at 9:24 AM and 3:19 PM with the Assistant Director of Nursing (ADON) #1 revealed she had taken the order on 09/05/14 for Resident #1 to change the treatment from twice a day to every shift. She stated the order would have to be put in the computer system to ensure it was printed on the TAR. She was unable to give an explanation as to why the order was not on the TAR prior to 09/10/14. Interview with the Director of Nursing (DON), on 09/16/14 at 8:06 AM, revealed she did not know why the wound was not measured because it had to be open to attract flies, and she had seen some skin assessments missing and some wounds were not measured. Further interview with the DON, on 09/17/14 at 9:20 AM, revealed the ADONs were supposed to measure pressure and non-pressure wounds. The DON further revealed she instructed staff that anything on the non-pressure sheet should have had a measurement. She stated the ADONs were aware they were supposed to measure the pressure and non-pressure areas. The DON further revealed the area on the resident's right hand was only 3 cm x 3 cm upon admission, and had been noted as a cyst. The DON stated she was trying to figure out how it got from a cyst to present day. She stated she could not have made it clearer to staff that if they did not complete the admission assessment and non-pressure skin condition and pressure condition records there would be consequences. Interview, on 09/18/14 at 7:53 AM and 2:02 PM with Resident #1's Physician revealed he did not expect maggots to be in the resident's wound and if dressings are not changed they can get dirty and could become infected.

2. Record review revealed the facility admitted Resident #3 on 08/15/14 with [DIAGNOSES REDACTED]. Review of the Initial Minimum Data Set (MDS) Assessment, dated 08/22/14, revealed the facility assessed the resident's cognition as moderately impaired with a Brief Interview for Mental Status (BIMS) score of ten (10) which indicated the resident was interviewable. Review of the Comprehensive Care Plan for Resident #3 revealed on 08/25/14 the problem was addressed as, Resident has disruption of surface, not related to pressure, has abdominal surgical wound. The goal stated, the resident's disruption of skin surface will remain free from infection and show evidence of healing by: (no date was entered) The intervention stated as of 08/25/14: Report changes in skin status to physician, provide diet as ordered and monitor nutritional status and dietary needs; consult dietician PRN, monitor for pain and medicate PRN per physician orders [REDACTED]. Review of the physician's orders [REDACTED]. Review of Resident #3's August and September Treatment Administration Record (TAR) revealed staff should cleanse wound to abdomen with normal saline, apply normal saline wet to dry dressing and cover with dry dressing twice daily. Interview with Resident #3, on 09/17/14 at 8:07 AM, revealed nurses occasionally administered more dressing changes in addition to the physician ordered twice daily treatments to the abdomen wound. Resident #3 stated that he/she was receiving three to four dressing changes a day due to more drainage from the abdominal wound. The resident stated that drainage had increased and was more excessive when ambulatory. Interview on 09/17/14 at 5:01 PM with Registered Nurse (RN) #1 revealed she provided care to Resident #3 and had changed the dressing more than ordered because of the dressing being saturated. RN #1 further revealed she knew the order was for twice a day, but if the dressing was dirty she would change it no matter what. She stated she had to change it more because it would be saturated, especially if Resident #3 was up and ambulating. Interview on 09/18/14 at 8:26 AM with Licensed Practical Nurse (LPN) #3 revealed she usually did three (3) dressing changes for Resident #3 because of the drainage. She stated dressings were supposed to be done every shift, and she knew she had to do it more than once and she did not know if the order said every shift or as needed. LPN #3 further revealed she had not spoken with the physician related to the dressing changes, she just did what the computer told her to do according to the treatment. She stated the treatment was every shift and had been as long as resident had been there. Interview on 09/18/14 at 10:48 AM with RN #2 revealed she was not assigned to change Resident #3 dressing but she did so if it was soiled or she was asked to change it by the resident. RN #2 could not recall the orders for the resident. She stated she had not called the physician about changing the dressings, but she had passed the information to the oncoming shift. Further record review revealed there was no documented evidence of wound dressing treatments administered other than the twice daily on August and September TARs. In addition, there was no documented evidence the physician had been notified of the additional needed dressing changes due to the increased drainage. Interview on 09/18/14 at 10:17 AM with Resident #3's Physician revealed he would expect to be notified if the resident was having additional dressing changes related to increased drainage.