



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/15/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185112	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/28/2013
NAME OF PROVIDER OR SUPPLIER NIM HENSON GERIATRIC CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 420 JETT DRIVE JACKSON, KY 41339	
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F 000	INITIAL COMMENTS An abbreviated survey (KY20365) was initiated on 06/25/13 and concluded on 06/28/13. The complaint was substantiated with deficiencies cited at "G" level, with an opportunity to correct.	F 000	This plan of correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of the plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of corrections is submitted to meet requirements established by state and federal law.	
F 157 SS=G	483.10(b)(1) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157	Resident #1 went to a physician's appointment on 6-6-13 and did not return to facility. A "notification of change" compliance audit was completed on 8-1-13 by Don and Nurse Supervisor for all current residents. This included comparing all orders/assessments from 5/22/13 for accuracy of detailed assessment, notification of changes (MD, resident and/or family) and care plan adjustments to current resident medical status. All issues were corrected by above or by notifying the responsible party (nursing or MD) who made correction. In-service was held 7/5/13 by DON/Supervisor/MDS for all nursing staff pertaining to when and how to initiate notification of changes. Policy was revised (attachment 1A, 1B and 1C.) The DON/Supervisor/designee will review The 24 hour report/order during the daily	

LABORATORY USE ONLY OR PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER'S SIGNATURE

Phillip Federal

TITLE
Administrator

(X6) DATE
8-6-13

Any deficiency statement written 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.

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F 157	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interviews, closed medical record review, hospital record review and review of the facility's policy, it was determined the facility failed to immediately notify an interested family member and/or the resident's physician when there was a significant change in the resident's status and a need to alter the treatment for one of four sampled residents (Resident #1). Resident #1 was admitted on 05/22/13, with three surgical incisions to the right leg. The resident had a follow-up appointment on 06/06/13 and at that time was diagnosed with an infection of the surgical incisions. Resident #1 was admitted to the hospital for treatment of the infection. However, based on documentation and interviews, the facility failed to ensure Resident #1's interested family member and/or the resident's physician had been notified of the changes in the surgical incisions that occurred prior to the follow-up visit conducted on 06/06/13, and that had the potential to require physician intervention. (Refer to F278 and F309.) The findings include: Review of the facility's undated policy entitled "Notification of Changes in a Resident's Condition" revealed a licensed nurse would be responsible for assessing the resident and notifying the resident's attending physician, the resident's responsible party, the Director of Nursing (DON) and the Minimum Data Set (MDS) Coordinator when there was a significant change	F 157	meeting. Any notification compliance issues will be addressed during the shift. 25% of all residents will be audited by same for all aspects "notification of change" compliance. Charting will be checked for accuracy and completion and compared to actual resident. This protocol will be used for 30 days beginning 8-1-13 at which time it will be reviewed to verify compliance is being met. The person responsible for correcting any monitoring issue will be notified verbally or by notification of documentation form. The process will continue if compliance is being met or revised if necessary. QA committee will be consulted if problem with compliance continue. Completion date:	8-8-13	

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F 157	<p>Continued From page 2</p> <p>in the resident's status and/or condition. The review revealed staff was responsible to document all changes in the resident's condition on the 24-hour report and the three-part condition change form.</p> <p>Review of Resident #1's closed medical record revealed the facility admitted the resident for rehabilitation on 05/22/13, with a diagnosis of Open Reduction and Internal Fixation (ORIF) of the right hip. Staff conducted a skin assessment of Resident #1 upon admission and noted the resident had three incisions; the first incision had fifteen staples, and the second and third incisions had four staples each. Review of physician's orders and the Treatment Administration Records (TARs) from 05/22-29/13, revealed staff was to monitor the surgical sites to the resident's right hip and upper outer leg twice a day. Review of Resident #1's medical record, which included the skin assessments and the Treatment Administration Records (TARs), revealed facility staff failed to document a description of the appearance of the three incisions to the resident's hip from the time of admission (05/22/13) until the resident's discharge (06/06/13).</p> <p>Review of Resident #1's Physician Notes from a follow-up appointment on 05/29/13, revealed the resident had some "cellulitis" (inflammation) to the distal end of the incision with no active drainage noted. Continued review of documentation by the physician on 05/29/13, revealed Resident #1's physician ordered staff to administer 500 milligrams (mg) of Keflex (antibiotic) to the resident three times a day. The physician also requested staff to assess the incisions on a daily basis when the dressings</p>	F 157			

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F 157	<p>Continued From page 3</p> <p>were changed and to arrange for a follow-up appointment on 06/06/13. The review revealed, "the resident can follow up sooner if there are increasing signs of infection."</p> <p>Review of Resident #1's TARs revealed from 05/30/13 through 06/06/13, staff applied an Allevyn patch (adhesive surgical dressing to aid healing) to the surgical sites on the resident's right hip and upper outer leg every day as ordered during the resident's follow-up appointment on 05/29/13. Based on documentation, staff also continued to monitor the resident's surgical sites twice a day, as previously ordered. However, staff failed to document a description of the resident's surgical incisions.</p> <p>Review of a Discharge Summary by Occupational Therapist (OT) #1 revealed Resident #1 was discharged from therapy on 06/06/13, after a "follow-up" appointment with the physician. According to documentation by the therapist, Resident #1 was admitted to the hospital on 06/06/13, due to Osteomyelitis (infection of the bone).</p> <p>Review of documentation in the hospital medical record by nursing staff, dated 06/06/13, at 4:30 PM revealed the incision to Resident #1's lateral right hip was red, warm, and had a "thick yellow drainage" to the distal parts of the incision. In addition, nursing documentation in the hospital medical record dated 06/06/13, at 9:00 PM revealed the surgical wounds to the resident's right hip were "poorly approximated" (areas of separation) with "yellow drainage" and redness noted.</p>	F 157			

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F 157	<p>Continued From page 4</p> <p>Review of a History and Physical documented in the hospital medical record by a physician on 06/06/13, revealed Resident #1 had been seen in the physician's office "a week ago" (05/29/13) and the resident's lower incision was "slightly open and draining." The review revealed on 06/06/13 the resident was found to have an infection to the right leg incision. Further review revealed Resident #1 was admitted to the hospital for an Incision and Drainage (I&D) of the incision.</p> <p>Review of Physician's Progress Notes/doctor's orders in the hospital medical record dated 06/06/13, revealed the orthopedic physician noted Resident #1's surgical incision had erythema (reddening of the skin due to inflammation) and purulent drainage (a discharge of pus). Resident #1 was admitted to the hospital for an Incision and Drainage (I&D) of the incision due to an abscess of the surgical incisions.</p> <p>Review of a consultation from an Infectious Disease physician, dated 06/06/13, revealed Resident #1 reported having an increase in pain and discharge from the right hip. Continued review of the physician's consult revealed Resident #1 had been placed on oral antibiotics; the pain and drainage worsened; and, there was some dehiscence (opening) of the incision. The documentation revealed the resident was admitted to the hospital for further evaluation and a plan to undergo an "irrigation and debridement" of the right hip incision. The documentation also revealed cultures of the surgical incisions were obtained and antibiotics were initiated.</p> <p>A review of the hospital Discharge Summary</p>	F 157		

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F 157	<p>Continued From page 5</p> <p>dated 06/11/13, revealed Resident #1 was admitted on 06/06/13, and was discharged home on 06/10/13, with a diagnosis of Methicillin-Resistant Staphylococcus Aureus (MRSA) of the right hip status post incision and drainage. The Discharge Summary stated, "Patient unfortunately did not have [his/her] dressing changed at least for 10 days."</p> <p>Interview conducted via telephone on 06/26/13, at 1:00 PM with Resident #1 revealed that prior to the resident's admission to the facility, a nurse at the hospital applied a dressing to the incisions on the resident's right hip and leg, and the dressings remained in place when the resident was admitted to the facility on 05/22/13. The resident stated nursing staff at the facility did not change the dressing to his/her right hip and leg for the first week he/she was at the facility. According to Resident #1, when he/she questioned why the dressing was not being changed the nursing staff informed the resident there was no physician's order to change the dressing. Resident #1 reported that during the follow-up appointment on 05/29/13, the physician was upset and questioned the resident concerning the dressing being soiled and not changed. The resident informed the physician the staff did not have an order for dressing changes. The interview revealed the physician informed the resident the incisions were infected and the physician wrote orders for oral antibiotics and daily dressing changes. Resident #1 stated that following the physician visit, nursing staff at the facility changed the dressing every day and there was drainage noted on the dressing being removed. The resident stated that one nurse at the facility said the incisions "didn't look good" but never</p>	F 157			

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F 157	<p>Continued From page 6</p> <p>explained what that meant. The interview revealed after a follow-up visit with the physician on 06/06/13, the resident was admitted to the hospital where the incisions were re-opened and cleansed. Further interview with Resident #1 revealed at the time of the interview he/she continued to receive intravenous (IV) antibiotics and was to continue the antibiotics for three weeks. Resident #1 had been discharged from the facility on 06/06/13, and an observation of the resident's incisions was not conducted.</p> <p>An attempt to interview Resident #1's family member on 06/25/13, at 8:25 AM was unsuccessful. However, review of correspondence dated 06/17/13, from Resident #1's family member revealed the resident had informed the family member the dressings to his/her surgical incisions had not been not changed during the stay at the facility. The letter revealed the family member was unaware of the infection to the incisions until the resident's follow-up appointment with the surgeon on 06/06/13.</p> <p>Interview conducted on 06/25/13, at 3:50 PM with Licensed Practical Nurse (LPN) #5 and review of documentation on the TARs in Resident #1's medical record at the facility revealed the LPN assessed the resident's incisions at the facility on 05/24-26/13, and on 06/01-06/13. The interview revealed the incision had a slight amount of redness at the distal end of the incision which worsened when dressings were initiated on 05/29/13. LPN #5 stated she noticed a change in the condition of the resident's surgical incisions; however, according to LPN #5, she did not notify the physician because the physician had placed</p>	F 157		

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F 157	Continued From page 7 the resident on antibiotics on 05/29/13 and had scheduled the resident for a follow-up appointment. Interview conducted on 06/25/13, at 7:00 PM with LPN #6 and review of Resident #1's TARs revealed the LPN assessed the resident's incisions on 05/22-23/13, 05/27/13, 05/31/13, and on 06/01-02/13, and 06/05-06/13. The interview revealed the incisions were slightly red upon admission and increased in redness during the resident's stay; however, LPN #6 stated she had not notified the resident's physician or the resident's family member of the change in the status of the resident's incisions. Interviews conducted on 06/25/13, at 5:50 PM with the DON and Registered Nurse (RN) #2 confirmed the facility's policy was to notify the resident's physician of changes in a resident's condition. The interview revealed the DON and RN #2 were not aware there had been a change in Resident #1's incision, and were not aware if facility staff had notified the resident's family member or physician of the changes.	F 157			
F 278 SS=C	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed.	F 278	Resident #1 went to a doctor's appointment on 6-6-13 and did not return to facility. A complete assessment compliance audit was completed on 8-1-13 by DON/Nurse Supervisor for all current residents. This included comparing all aspects of resident assessments from 5-22-13 by viewing resident for completion and accuracy. All issues were corrected by the above or by		

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F 278	<p>Continued From page 8</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, closed medical record review, hospital record review, and review of the facility's policy, it was determined the facility failed to ensure assessments accurately reflected the resident's status for one of four sampled residents (Resident #1). Resident #1 was admitted to the facility with three surgical incisions to the right leg. However, based on documentation and staff interviews, the facility failed to document assessments of the status of the resident's surgical incisions in an effort to coordinate the resident's care with the appropriate health professionals. On 06/06/13, the resident was assessed by a physician during a follow-up appointment and diagnosed with an</p>	F 278	<p>notifying the responsible person who made correction.</p> <p>The nursing assessment/interim care plan, daily wound documentation was revised to include surgical wounds. Staff was in-serviced by DON and Supervisor on 6/20/13 regarding documentation of wounds and on 8/2/13 regarding the accuracy of all assessments done on admits and re-admits (see attachments 3A, 3B and 5.)</p> <p>The DON/Supervisor/designee will review the 24 hour report and orders during the morning meeting. Any assessment compliance issues will be addressed during that shift. Correction will be made by the above or responsible employee which will be notified verbally or by communication form for correction. All wound documentation and assessments will be reviewed weekly by the NAR committee. This includes Nurse supervisor/designee visibly looking at resident for assessment accuracy to include wounds. This protocol will be used for 30 days beginning 8-1-13 at which time it will be reviewed to verify compliance is being met. This process will continue if achieving goal or revised as necessary. QA committee will be consulted if problems with compliance continue.</p> <p>Completion Date:</p>	8-8-13

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F 278	<p>Continued From page 9</p> <p>infection to the surgical incisions that required admission to a hospital for further treatment. (Refer to F309.)</p> <p>The findings include:</p> <p>Review of the facility's undated policy entitled "Wound Documentation" revealed staff was responsible to document daily on all wounds which included pressure ulcers, surgical wounds, and skin tears. The policy revealed the staff would document the wound's status on the back of the Treatment Administration Record (TAR).</p> <p>Review of Resident #1's closed medical record revealed the facility admitted the resident for rehabilitation on 05/22/13, with a diagnosis of Open Reduction and Internal Fixation (ORIF) of the right hip. At the time of admission, facility staff assessed the resident and noted the resident had a surgical incision that had fifteen staples and two surgical incisions that had four staples each. Review of Physician's Orders and the TARs for May 2013 revealed staff was to monitor the surgical sites to the right hip and upper outer leg twice a day. However, based on review of documentation in Resident #1's medical record, including the skin assessments and the Treatment Administration Record (TAR), facility staff failed to document a description of the appearance of the three incisions and had only documented how many staples were in each incision.</p> <p>Review of Resident #1's closed medical record revealed an Admission Minimum Data Set (MDS) assessment dated 06/03/13. The review revealed the resident's cognition was intact. The</p>	F 278		

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F 278	<p>Continued From page 10</p> <p>MDS assessment also revealed the resident had surgical wounds; however, facility staff failed to document the appearance of the three incisions.</p> <p>Further review of the clinical record revealed Resident #1 was assessed by a physician during a follow-up appointment on 05/29/13; and documentation from the follow-up appointment revealed the physician requested for staff to administer 500 milligrams (mg) of Keflex (antibiotic) three times a day due to inflammation to the distal end of the surgical incision. In addition, the physician requested staff to monitor the resident's wounds/incisions and change the dressings to the wounds/incisions on a daily basis. Resident #1 was to return to the physician's office for a follow-up appointment on 06/06/13 or "sooner" if there were increasing signs of infection. Review of documentation by the physician following the follow-up visit on 05/29/13, revealed Resident #1 had "cellulitis" (inflammation which is red, hot, and painful) of the incisions "distally," with no active drainage noted.</p> <p>Review of documentation on the TARs revealed staff applied an Allevyn patch (surgical dressing) to the surgical sites on Resident #1's right hip and upper outer leg every day from 05/30/13 through 06/06/13. Although facility staff had noted the resident's incisions had been monitored twice a day, facility staff failed to document an assessment, including a description, of the status of the surgical incisions.</p> <p>Review of documentation by Occupational Therapist (OT) #1 dated 06/11/13, revealed Resident #1 was admitted to a hospital after a</p>	F 278			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/15/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185112	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/28/2013
NAME OF PROVIDER OR SUPPLIER NIM HENSON GERIATRIC CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 420 JETT DRIVE JACKSON, KY 41339		
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F 278	<p>Continued From page 11</p> <p>follow-up visit with the physician on 06/06/13, secondary to Osteomyelitis (bone infection).</p> <p>Review of nurse's notes in Resident #1's hospital medical record dated 06/06/13, at 4:30 PM revealed the surgical incision to Resident #1's right hip was red, warm, and had "thick yellow" drainage at the distal parts of the incision. Further review of the hospital's nurse's notes dated 06/06/13, at 9:00 PM revealed the surgical incisions on the resident's right hip were poorly approximated (edges are brought together without areas of separation), were red, and had "yellow drainage."</p> <p>Review of a History and Physical documented by the physician at the time of Resident #1's admission to the hospital on 06/06/13, revealed Resident #1 had been seen in the physician's office a "week ago" (05/29/13) and the resident's lower incision was slightly opened and draining. Further review revealed on 06/06/13, the resident was admitted to the hospital for an Incision and Drainage (I&D) of the incision due to an infection. Resident #1 was discharged home from the hospital on 06/10/13, and an observation of the resident's incision was not conducted during the investigation.</p> <p>Review of progress notes/doctor's orders dated 06/06/13, revealed an Orthopedic Physician at the hospital assessed Resident #1 and noted the resident's incision was red and had a "purulent" discharge. Resident #1 was admitted for an Incision and Drainage (I&D) of an abscess at the surgical incision.</p> <p>Review of an Infectious Disease Consultation</p>	F 278		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/15/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185112	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/28/2013
NAME OF PROVIDER OR SUPPLIER NIM HENSON GERIATRIC CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 420 JETT DRIVE JACKSON, KY 41339		
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F 278	<p>Continued From page 12</p> <p>dated 06/06/13, revealed Resident #1 had reported an increase in pain and a discharge from the right hip. Documentation revealed the resident was placed on oral antibiotics, the pain and drainage worsened, the incision had some dehiscence, and the resident was admitted to the hospital for further evaluation/treatment.</p> <p>In addition, a review of Resident #1's hospital Discharge Summary dated 06/11/13, revealed the resident was admitted on 06/06/13, and was discharged home on 06/10/13, with a diagnosis of Methicillin-Resistant Staphylococcus Aureus (MRSA) of the right hip. The Discharge Summary revealed the "patient unfortunately did not have [his/her] dressing changed at least for 10 days."</p> <p>Interview conducted on 06/25/13, at 2:30 PM with Licensed Practical Nurse (LPN) #1 and review of the TARs for Resident #1 revealed the LPN assessed the resident's incisions on 05/22/13, 05/23/13, 05/27/13, and 05/28/13, but failed to document a description of the appearance of the resident's incisions. The interview with LPN #1 revealed there was no dressing to the resident's incisions and "no redness or drainage" noted. However, LPN #1 failed to document a description of the resident's incisions.</p> <p>Interview conducted on 06/25/13, at 2:50 PM with LPN #2 and review of the TARs for Resident #1 revealed the LPN assessed the resident's incisions on 05/28-30/13. LPN #2 stated the resident's incision was covered with a dressing and when the LPN changed the dressing there was no redness or drainage noted. However, the LPN failed to document a description of the</p>	F 278		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/15/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185112	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/28/2013
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F 278	<p>Continued From page 13 resident's incisions.</p> <p>Interview conducted on 06/25/13, at 3:05 PM with LPN #3 and review of Resident #1's TARs revealed the LPN assessed the resident's incisions on 05/24-26/13 and the incisions were left open to air with no redness or drainage noted. Further interview and review of the TAR revealed LPN #3 also assessed and provided incision care for Resident #1 on 06/03-04/13, and with the dressing changes there was no redness or drainage of the incisions noted at that time. However, LPN #3 failed to document a description of the resident's incisions.</p> <p>Interview conducted on 06/25/13, at 3:30 PM with LPN #4 and review of Resident #1's TARs revealed the LPN assessed the resident's incisions on 05/24-26/13 and again on 05/29/13. The LPN stated the resident's incisions were covered with a dressing and when the LPN changed the dressing there was no redness or drainage noted. However, the LPN failed to document a description of the resident's incisions.</p> <p>Interview conducted on 06/25/13, at 3:50 PM with LPN #5 and review of Resident #1's TARs revealed the LPN assessed the resident's incisions on 05/24-26/13, and on 06/01-06/13. The interview revealed the incision had a slight amount of redness at the distal end of the incision which worsened when the dressing started being applied. LPN #5 stated she noticed a change in the incisions but had failed to document a description of the resident's incisions.</p> <p>Interview conducted on 06/25/13, at 7:00 PM with LPN #6 and review of Resident #1's TARs</p>	F 278			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/16/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185112	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/28/2013
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F 278	Continued From page 14 revealed the LPN assessed the resident's incisions on 05/22/13, 05/23/13, 05/27/13, 05/31/13, 06/01/13, 06/02/13, 06/05/13, and 06/06/13. The interview revealed the incision was slightly red upon admission and increased in redness during the resident's stay at the facility. However, the LPN failed to document a description of the resident's incisions. Interviews conducted on 06/25/13, at 5:50 PM with the Director of Nursing (DON) and Registered Nurse (RN) #2 revealed facility staff was to document an assessment of a resident's wounds on a daily basis in accordance with the facility's policy. According to interview with the DON and RN #2, the wound assessments were to be documented on the back of the TARs. After reviewing Resident #1's closed medical record the DON and RN #2 confirmed there was no documented assessment of the resident's incisions or of a change in the condition of the resident's incisions.	F 278		
F 279 SS=G	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's	F 279	Resident #1 went to a doctor's appointment on 6-6-13 and did not return to facility. An audit of all resident comprehensive care plans was completed on 8-1-13 by DON/Nurse Supervisor. This included checking resident care plan from 5-22-13 against comprehensive assessments for completion and accuracy. No resident was found to be out of compliance. The assessment form for admit/re-admit was revised (3A). Interim care plan will address all current medical needs. This	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/15/2013
FORM APPROVED
OMB NO. 0938-0391

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F 279	<p>Continued From page 15</p> <p>highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, closed medical record review, and hospital record review, it was determined the facility failed to develop a care plan to describe the services to be furnished to attain or maintain the highest practicable physical well-being for one of four sampled residents (Resident #1). Resident #1 was admitted to the facility with three surgical incisions to the right leg; however, the facility failed to develop a care plan to address the care to be provided to the surgical incisions. On 06/09/13, Resident #1 was assessed by the physician during an office visit and diagnosed with an infection of the surgical incisions; and was admitted to the hospital for treatment of the infection. (Refer to F309.)</p> <p>The findings include:</p> <p>According to the Director of Nursing (DON), although the facility did not have a written policy for the development of a care plan upon admission, staff was to develop an admission working care plan and a nurse aide care plan. According to the DON, the facility had an "Admission Check List" which was completed by the admitting nurse upon each resident's admission to ensure staff developed the</p>	F 279	<p>will be done on all admits/re-admits. Staff in-serviced on 7-5-13 by DON/designee and 8/1/13.</p> <p>The interim care plan will be monitored for accuracy, along with all assessments completed on admits/re-admits. These will be compared to the resident's current medical condition for accuracy by DON/Supervisor/Designee on next business day (4A and 4B). Wounds will be visibly observed by DON/Designee every week to verify interim care plan compliance. This protocol will be used for 30 days beginning 8/1/13 and then re-assessed to ensure all issues are identified and resolved. This process will continue if achieving goal or revised as necessary. Any problems will be presented to QA committee. Any compliance issues will be corrected by person doing audit or referred to responsible party for completion.</p> <p>Completion Date:</p>	8-8-13

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/15/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185112	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/28/2013
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F 279	<p>Continued From page 16</p> <p>admission working care plan and the aide care plan. The DON reported that the Minimum Data Set (MDS) Coordinator also utilized the "Admission Check List" to develop the comprehensive care plan within 21 days of admission.</p> <p>Review of the closed medical record for Resident #1 revealed the facility admitted the resident on 05/22/13 for rehabilitation. Resident #1's diagnosis at the time of admission was Open Reduction and Internal Fixation (ORIF) of the right hip. A skin assessment conducted upon admission to the facility revealed the resident had three intact incisions; the first incision had fifteen staples and the second and third incision both had four staples. Review of Resident #1's medical record, including the Treatment Administration Records (TARs) and physician's orders dated 05/22/13, revealed staff was to monitor the surgical incisions on the resident's right hip and upper outer leg twice a day. A review of documentation from a follow-up appointment on 05/29/13 revealed the resident's physician ordered 500 milligrams (mg) of Keflex (an antibiotic) to be administered to Resident #1 three times a day. In addition, the physician requested staff to conduct assessments of the resident's surgical incisions on a daily basis with dressing changes. Documentation revealed Resident #1 had a follow-up appointment with the physician on 06/06/13, and was diagnosed with an infection of the right hip incision and hospitalized for treatment.</p> <p>Review of Resident #1's hospital Discharge Summary dated 06/11/13, revealed the resident was admitted to the hospital on 06/06/13, and</p>	F 279			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/15/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185112	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/28/2013
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F 279	<p>Continued From page 17</p> <p>was discharged home on 06/10/13, with a diagnosis of Methicillin-Resistant Staphylococcus Aureus (MRSA) of the right hip infection status post incision and drainage. The Discharge Summary revealed, "Patient unfortunately did not have [his/her] dressing changed at least for 10 days."</p> <p>Review of Resident #1's care plan revealed facility staff had failed to ensure a care plan had been developed to address the resident's incisions, including the potential for infection, and failed to develop interventions to ensure the resident's surgical incision healed without complications.</p> <p>Interview conducted on 06/25/13, at 5:50 PM with Registered Nurse (RN) #2 revealed the nurse who completed the admission was responsible for developing a working care plan for residents in the facility based on their care needs. The interview revealed the MDS Coordinator would develop a comprehensive care plan within 21 days of admission along with the completion of the MDS assessment. RN #2 stated Resident #1 had only been a resident in the facility for 16 days and a comprehensive care plan had not been developed. RN #2 acknowledged the "working" care plan failed to include interventions related to the potential for the development of infection of the surgical incisions.</p> <p>Interview conducted on 06/25/13, at 7:00 PM with LPN #6 revealed the nurse performed the admission assessment for Resident #1 on 05/22/13, and the working care plan. However, the working care plan failed to address the care to be provided to the resident's incisions.</p>	F 279		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/15/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125112	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/28/2013
NAME OF PROVIDER OR SUPPLIER NIM HENSON GERIATRIC CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 420 JETT DRIVE JACKSON, KY 41339	
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F 309 SS=G	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, closed medical record review, hospital record review and review of the facility's policy, it was determined the facility failed to ensure one (1) of four (4) sampled residents (Resident #1) received the necessary care and services to maintain the highest practical physical well-being. Resident #1 was admitted to the facility on 05/22/13, with three (3) surgical incisions to the right leg. On 06/06/13, Resident #1 was assessed during a follow-up visit with the physician and diagnosed to have infection to the incisions. Resident #1 was admitted to the hospital on 06/06/13, for treatment of the infection. The facility failed to ensure facility staff developed a care plan that included interventions to ensure the resident's surgical incisions healed without complications; failed to ensure facility staff assessed and documented a description of the resident's surgical incisions, including significant changes in the appearance of the surgical incisions. (Refer to F157, F278, and F279)</p>	F 309	<p>Resident #1 went to a physician's appointment on 6-6-13 and did not return to facility.</p> <p>On 8/1/13 a compliance audit was conducted by DON and Supervisor. This included: notification of changes, comprehensive assessments and care plans. All compliance issues were corrected by audit personnel and responsible employee.</p> <p>The re-admit/admit interim care plan nursing assessment and daily wound documentation have been revised to include surgical wounds and any current medical needs. (3A/3B.) This will be done with every admit and re-admit. The policy for notification of change in residents condition was revised (C1). Daily wound documentation was revised (see attachment 5). In-service by DON/Supervisor/MDS was given to staff on 6/20/13 on above revisions. An in-service was held on 7-5-13 by DON/Supervisor/MDS for all nursing staff pertaining to when and how to initiate notification of changes. Policy revised (1A,1B,and 1C.) In-service on 8-2-13 regarding the accuracy of all assessments done with admit/re-admit.</p> <p>During morning meeting the DON/Supervisor/designee will review all 24 hour report sheets and orders from the previous day. Any discrepancies will be addressed during that shift.</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185112	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/28/2013
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F 309	Continued From page 19 The findings include: Review of the facility's policy entitled "Notification of Changes in a Resident's Condition," undated, revealed staff was to notify the resident, the resident's attending physician, the resident's responsible party, the Director of Nursing and the MDS Coordinator of changes in the resident's condition. The policy revealed a licensed nurse would be responsible for assessing the resident and notifying the resident's attending physician, the resident's responsible party, the Director of Nursing and the MDS Coordinator when there had been a significant change in the resident's status. The review revealed staff was responsible to document all changes in the resident's condition on the 24-hour report and the three-part condition change form. Review of the facility's policy entitled "Wound Documentation," undated, revealed staff was responsible to document daily on all wounds which included pressure ulcers, surgical wounds, and skin tears. The policy revealed the staff would document the wound's status on the back of the Treatment Administration Record (TAR). Review of Resident #1's closed medical record revealed the facility admitted the resident for rehabilitation on 05/22/13 with a diagnosis of Open Reduction and Internal Fixation (ORIF) of the right hip. Facility staff conducted a skin assessment upon the resident's admission to the facility and noted the resident had three (3) intact incisions that included one (1) with fifteen (15) staples and two (2) with four (4) staples each. However, review of Resident #1's medical record,	F 309	25% of all residents will be audited monthly by DON/Supervisor/designee for compliance with MD orders and notifications (MD and Family) and care plan updates. All assessments completed on admit/re-admit will be compared to the resident's current medical condition for accuracy by DON/Supervisor/designee (4A and 4B). Wound documentation and assessment will be reviewed on a weekly basis at NAR meeting. Nurse supervisor/designee will visibly assess each wound weekly. Resident admit/re-admit assessment and care plan documentation will be monitored for compliance by DON on next business day (4A/4B). This protocol will be used for 30 days starting 8-1-13 and then re-assessed to ensure all issues are identified and resolved. Any compliance issues will be corrected by person doing audit and referred to responsible party for completion. Completion Date:	8-8-13	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/15/2013
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F 309	<p>Continued From page 20</p> <p>including the skin assessments and the Treatment Administration Records (TARs), revealed facility staff failed to document a description of the appearance of the three (3) incisions. Review of the TARs and physician's orders for May 2013 revealed staff was to monitor the surgical sites to the right hip and upper outer leg twice a day; however, there were no treatments ordered for the incisions until after a follow up appointment on 05/29/13, seven (7) days after the resident's admission to the facility. Review of documentation from the follow up appointment revealed Resident #1's had inflammation to the distal section of the incision and the physician requested staff to administer 500 milligrams of Keflex (antibiotic) to Resident #1 three times a day; to conduct daily incision assessment with dressing changes; and for the resident to return to the physician's office on 06/06/13, for a follow-up appointment or "sooner if there are increasing signs of infection".</p> <p>Review of Resident #1's clinical record revealed from 05/30/13, through 06/06/13, staff applied an Alleyvn patch (surgical dressing) to Resident #1's surgical site on the right hip and upper outer leg every day; however, staff failed to document a description of the status of the surgical incisions.</p> <p>Review of Resident #1's care plan revealed facility staff had failed to ensure a care plan had been developed to address the resident's incisions, including the potential for infection, and failed to develop interventions to ensure the resident's surgical incision healed without complications.</p> <p>Interview conducted on 06/25/13, at 5:50 PM with</p>	F 309		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/15/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185112	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/28/2013
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NAME OF PROVIDER OR SUPPLIER NIM HENSON GERIATRIC CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 420 JETT DRIVE JACKSON, KY 41339
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F 309	<p>Continued From page 21</p> <p>Registered Nurse (RN) #2 revealed the nurse who completed the admission was responsible for developing a working care plan for residents in the facility based on their care needs. The interview revealed the MDS Coordinator would develop a comprehensive care plan within twenty-one (21) days of admission along with the completion of the MDS assessment. RN #2 stated Resident #1 had only been a resident in the facility for sixteen (16) days and a comprehensive care plan had not been developed. RN #2 acknowledged the "working" care plan failed to include interventions related to the potential for the development of infection of the surgical incisions.</p> <p>Documentation in Resident #1's medical record revealed Resident #1 was admitted to a hospital on 06/06/13, secondary to an infection of the surgical incisions.</p> <p>Review of a hospital History and Physical dated 06/06/13, revealed Resident #1 was seen in the physician's office "a week ago" (05/29/13) and the resident's lower incision was slightly opened and draining. The review revealed the physician assessed Resident #1 again on 06/06/13, and documented the resident had an infection to the right leg incision and was admitted to the hospital.</p> <p>Review of documentation by an Orthopedic physician at the hospital on 06/06/13, revealed Resident #1 had erythema (reddening of the skin due to inflammation) and purulent drainage (discharging of pus) from the surgical incision and was admitted to the hospital due to an abscess (a collection of pus) of the incisions.</p>	F 309		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/15/2013
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F 309	<p>Continued From page 22</p> <p>An Infectious Disease Consultation on 06/06/13 revealed Resident #1 had an increase in pain and discharge from the right hip incision and had been placed on oral antibiotics. Based on the Infectious Disease Consultation, the resident's pain and drainage from the incision had worsened, some dehiscence of the incision had occurred, and Resident #1 was admitted to the hospital for further evaluation. Documentation revealed an irrigation and debridement of the surgical incision on Resident #1's right hip was conducted, cultures were obtained, and antibiotics were initiated.</p> <p>A review of Resident #1's hospital Discharge Summary dated 06/11/13, revealed the resident had been admitted to the hospital on 06/06/13, and was discharged home on 06/10/13, with a diagnosis of Methicillin-Resistant Staphylococcus Aureus (MRSA) of the surgical incision on the right hip. According to the Discharge Summary, the "Patient unfortunately did not have [his/her] dressing changed at least for 10 days."</p> <p>Interview conducted on 06/26/13 at 1:00 PM, with Resident #1 revealed a nurse at the hospital had applied a dressing to the incisions on the right hip and leg which were in place when the resident was admitted to the facility on 05/22/13. The resident stated nursing staff at the facility did not change the dressing to his/her right hip and leg for the first week he/she was at the facility. According to Resident #1, when he/she questioned why the dressing was not being changed the nursing staff informed the resident there was no physician's order to change the dressing. Resident #1 reported that during the follow up appointment on 05/29/13, the physician</p>	F 309			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 309	<p>Continued From page 23</p> <p>was upset and questioned the resident concerning the dressing being soiled and not changed. The resident informed the physician the staff did not have an order for dressing changes. Resident #1 stated following the physician visit, nursing staff at the facility changed the dressing every day and there was drainage noted on the dressing being removed. The resident stated that one (1) nurse at the facility said the incisions "didn't look good" but never explained what that meant. The interview revealed after a follow up visit with the physician on 06/06/13, the resident was admitted to the hospital where the incisions were re-opened and cleaned out. Resident #1 stated he/she was still taking intravenous (IV) antibiotics and was to continue the antibiotics for the next three (3) weeks.</p> <p>An attempt to interview Resident #1's family member on 06/25/13, at 8:25 AM was unsuccessful. However, a review of correspondence, dated 06/17/13, from Resident #1's family member revealed the resident had informed the family member the dressings to his/her surgical incisions had not been not changed during his/her stay at the nursing home. Further review revealed Resident #1 and the family member were unaware of the infection to the incisions until the resident's follow up appointment with the surgeon on 06/06/13.</p> <p>Interview on 06/25/13, at 2:30 PM with Licensed Practical Nurse (LPN) #1 revealed the LPN assessed the resident's incisions on 05/22/13, 05/23/13, 05/27/13, and 05/28/13, and had failed to document the appearance of the resident's surgical incisions. LPN #1 stated the resident's</p>	F 309			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 309	<p>Continued From page 24</p> <p>incisions had been left open to air with no redness or drainage noted.</p> <p>Interview conducted on 06/25/13, at 2:50 PM with LPN #2 and review of Resident #1's TARs revealed the LPN assessed the resident's incisions on 05/28-30/13. According to LPN #2, the incision was covered with a dressing and when she changed the dressing she had not observed any redness or drainage of the incisions, and had failed to document the assessment.</p> <p>Interview conducted on 06/25/13 at 3:05 PM with LPN #3 revealed the LPN assessed the resident's incisions on 05/24-26/13, and the incisions had been left open to air with no redness or drainage noted. Further interview and review revealed LPN #3 also assessed and provided incision care for Resident #1 on 06/03-04/13, with no redness or drainage noted when the dressing was changed; however, there was no documentation of the appearance of the incisions.</p> <p>Interview conducted on 06/25/13, at 3:30 PM with LPN #4 revealed the LPN assessed the resident's incisions on 05/24-26/13, and again on 05/29/13. The LPN stated the resident's incisions were covered with a dressing and when the dressing was changed there was no redness or drainage noted; however, there was no documentation of the appearance of the incisions.</p> <p>Interview conducted on 06/25/13, at 3:50 PM with LPN #5 and review of Resident #1's TARs revealed the LPN assessed the resident's incisions on 05/24-26/13 and on 06//01-06/13. The interview revealed the incision had a slight</p>	F 309			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 309	<p>Continued From page 25</p> <p>amount of redness at the distal end of the incision which worsened when the dressing started being applied and would have been documented on the TARs. LPN #5 stated she noticed a change in the incisions; however, the LPN stated she failed to document the description of the incisions and had not notified the resident's family member or the resident's physician because the physician had started the resident on an antibiotic and already scheduled the resident for a follow-up appointment.</p> <p>Interview conducted on 06/25/13, at 7:00 PM with LPN #6 revealed the LPN assessed the resident's incisions on 05/22/13, 05/23/13, 05/27/13, 05/31/13, 06/01/13, 06/02/13, 06/05/13, and 06/06/13. The interview revealed the incision was slightly red upon admission and increased in redness during the stay; however, LPN #6 stated she had not documented the assessment and failed to notify the resident's family member or the resident's physician of the change in the resident's surgical incision.</p> <p>Interviews conducted on 06/25/13, at 5:50 PM with the Director of Nursing (DON) and Registered Nurse (RN) #2 confirmed the facility's policy was to notify the resident's physician of changes in a resident's condition. The interview revealed the nurses were to assess Resident #1's incisions daily and document the assessment on the TAR. However, the DON and RN #2 acknowledged facility staff had failed to always document the assessment of Resident #1's surgical incisions, including a description of the appearance of the wounds, as required by facility policy and confirmed there was no family member or physician notification of any changes in the</p>	F 309			

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F 309	Continued From page 26 resident's surgical incisions.	F 309		
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