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M 000	Initial Comments The State Agency (SA) conducted a Complaint Investigation (CI), MS #22783, at the facility on 10/5/23. The SA investigated MS #22783 related to call lights, rehabilitation services, and notification of the resident's change in condition. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirement and cited M500.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to	M 500		11/11/23

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M 500	Continued From page 1 participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this	M 500		

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responsibility to the facility for any period of time in conformance with State law;

7. is free from mental and physical abuse;
8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint;
9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract;

10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;

11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;

12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as

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M 500	Continued From page 3 documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level III Based on interviews, record review, and facility policy review, the facility failed to identify and provide treatment to an open scalp wound for one (1) of four (4) sampled residents. (Resident #1)	M 500	1. Resident #1 was sent to the emergency room on 9/18/2023 and discharged from the facility on 9/25/2023. 2. All Residents have the potential to be affected by the same deficient practice.	

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M 500	Continued From page 4 Findings Include: Review of the facility's policy, "Abuse Prevention Program", undated, revealed, " ...Our residents have the right to be free from ...neglect ..." Review of the facility's policy, "Skin Assessment" revised 11/1/2022, revealed " ...It is our policy to perform a full body skin assessment as part of our systemic approach to pressure injury prevention and management. This policy includes the following procedural guidelines in performing the full body skin assessment...Policy Explanation and Compliance Guidelines: 1. A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/ re-admission and weekly thereafter..." In a phone interview on 10/5/23 at 10:15 AM, with the Resident Representative (RR) and his wife, they stated they visited Resident #1 at the facility on 9/18/23 and the resident was wearing a bonnet. The wife stated that when she removed the bonnet, there was a bandage on her head that was discolored a brown color, and had no date written on the bandage to indicate when the bandage was applied. She said the area had drainage and was crusted around the edges, so she notified the nurse. The Nurse Practitioner (NP) assessed the resident and ordered the resident to be transferred to the hospital. The family revealed that when the resident arrived at the hospital, the hospital staff noted the bandages were unchanged. The family said the facility neglected to provide treatments to her scalp and failed to provide care to prevent a wound infection. Record review of the "Progress Note", dated 9/18/23, created by the facility's NP, revealed the	M 500	3. All nursing staff will be inserviced on the proper way to complete a body audit, abuse and neglect, and following the careplan by the director of nurse and staff development nurse. This inservice will be completed by 10/23/2023. All nurses will be observed by the staff development nurse performing a body audit by 10/23/23. the director of nursing, resident care coordinator and registered nurse supervisor completed a baseline body audit on all resident, completed on 10/17/23 4. The director of nursing will verify that the residents with known skin issues have accurate body audits completed. Director of Nursing will visualize current wound and compare to most recent body audits weekly x 12 weeks beginning 10/16/2023. The Resident Care Coordinator or Director of Nursing will complete 10 random body audits weekly x 12 weeks to verify that body audit is completed accurately, beginning 10/16/2023. All audits will be reviewed by the Quality Assurance and Assessment Committee x 3 months beginning 11/10/2023 to ensure sustained compliance.	

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M 500	Continued From page 5 "Chief Complaint/Nature of Presenting Problem" was "Wound infection of Scalp". The "History of Present Illness" was "Patient seen today per facility request for evaluation of wound infection for scalp ...Patient's family member is at bedside and reports concern for recurrent wound infection to her scalp. Patient currently has recurrent squamous cell carcinoma (a type of skin cancer) of her scalp and is currently receiving chemotherapy ...Patient previously treated ...in May. Scalp does have increased drainage and crusting with no foul odor noted ...Family request patient be sent to (Proper Name of Local Hospital) for further evaluation and treatment." Record review of a "Discontinue Order", dated 6/12/23, for Resident #1, revealed a Physician's Order for "...Cleanse scalp with wound cleanser pat dry Apply Mupirocin Ointment every day shift" was discontinued on 6/12/23 and the reason for discontinue was "Wound healed per (Proper Name of Physician)." This was the last Physician's Order related to treatments for Resident #1's scalp in the medical record. Record review of the of the "Discharge Summary Note", dated 9/25/23, from a local acute hospital revealed Resident #1 was admitted through the Emergency Department on 9/18/23 and was discharged from the hospital on 9/25/23, which was seven (7) days later. The "Hospital Course" of the summary note revealed, " ...At presentation, she had unchanged dressings on her wounds. Family was concerned of adult neglect at the facility ...Squamous cell carcinoma of scalp ...Known to dermatology ...and oncology ..." Record review of the " ...Skin Only Evaluation", dated 8/6/23, revealed Licensed Practical Nurse	M 500		

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(LPN) #2 documented that Resident #1 did not have current skin issues.

During a phone interview on 10/5/23 at 12:45 PM, with LPN #2, she confirmed she completed a skin evaluation, or body audit, for Resident #1 on 8/6/23. LPN #2 explained that she failed to remove the resident's bonnet to assess her scalp during the skin evaluation. She stated she was not aware the resident had a bandage on her scalp and that she did not apply the bandage.

Record review of the " ...Skin Only Evaluation", dated 8/13/23, revealed Licensed Practical Nurse (LPN) #3 documented that Resident #1 did not have current skin issues.

During a phone interview on 10/5/23 at 1:00 PM, with LPN #3, she confirmed she completed a skin evaluation/body audit for Resident #1 on 8/13/23. LPN #3 also confirmed she failed to remove the residents bonnet to assess her scalp. She explained she did not know there was a bandage on her scalp because she did not apply any bandages to the resident's head.

Review of the medical record revealed there were no skin evaluations for 8/20/23 or 8/27/23.

Record review of the " ...Skin Only Evaluation", dated 9/6/23, revealed Licensed Practical Nurse (LPN) #1 documented that Resident #1 did not have current skin issues.

During a phone interview on 10/5/23 at 12:30 PM, with LPN #1, she confirmed she completed a body audit for Resident #1 on 9/6/23. LPN #1 also confirmed she failed to remove the residents bonnet to assess her scalp area. She stated she did not apply any bandages to the resident's scalp

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and was not aware she had a bandage on her head.

Record review of the " ...Skin Only Evaluation", dated 9/10/23, revealed Registered Nurse (RN) #1 documented that Resident #1 did not have current skin issues.

During a phone interview on 10/5/23 at 12:15 PM, RN #1 confirmed she failed to do a complete head-to-toe skin assessment on 9/10/23 for Resident #1. RN #1 explained she assessed the resident's skin, but she did not remove the bonnet to assess her head. RN #1 said she was not aware that Resident #1 had a bandage to her scalp, and she did not apply a bandage to that area.

During an interview on 10/5/23 at 1:12 PM, with Certified Nursing Aide (CNA) #1, she stated that she provides care to the Resident #1. She explained that she removed the bonnet and saw a bandage on the resident's head and only cleaned around he bandage when she gave the resident a shower.

During an interview on 10/5/23 at 1:20 PM, with CNA #2, she explained she provided care for Resident #1 prior to her hospitalization. CNA #2 stated Resident #1 had a bandage on her head, and she washed around the bandage. She stated that she thought the nurses knew about the drainage on the wound and were taking care of it.

During an interview on 10/5/23 at 1:30 PM, with the facility's NP, she confirmed she assessed Resident #1 because the family had concerns with her scalp. The NP said the resident had been wearing a bonnet, and upon assessment she noted an area on the scalp that had

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increased drainage, that was dry and crusted around the wound edges. The NP said she agreed with the family and sent the resident to the Emergency Department (ED) for evaluation because the resident had signs of infection to the scalp. The NP said she did not culture the wound because the resident is immunocompromised, due to chemotherapy. The NP explained that residents who receive chemotherapy should be assessed frequently and closely monitored for infections. The NP said that the nurses should have completed head-to-toe skin assessments on the resident for early detection and to prevent infection.

During an interview on 10/5/23 at 1:45 PM, with the Director of Nursing (DON), she confirmed the staff failed to do a head-to-toe skin assessment on Resident #1 and she did not realize this was not being done. The DON said she expected the staff to assess the resident head-to-toe when completing body audits. The DON revealed she did not know the residents wound had re-opened until the family came to visit and had concerns. The DON said she started in-services with the staff on appropriate body audits and the importance of reporting changes on the resident's body.

During an interview on 10/5/23 at 2:00 PM, with the Administrator, he stated he expected staff to do a complete head-to-toe skin assessment to prevent further damage to a compromised Resident.

Record review of the "Admission Record" revealed the facility admitted Resident #1 on 1/04/23 with a diagnoses including Diabetes Mellitus and Carcinoma of the skin of scalp.

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M 500	Continued From page 9 Review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/18/23 revealed Resident #1 required a staff interview to assess cognition and her cognition was moderately impaired. Further review revealed she was totally dependent upon staff for Activities of Daily Living (ADL's).	M 500		