MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49WM	A. BUILDING: _____ B. WING _____	C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINONA MANOR HEALTH CARE AND REHABILITATIC	627 MIDDLETON ROAD WINONA, MS 38967

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M 000	Initial Comments The State Agency (SA) conducted Complaint Investigations (CI) at the facility for seven (7) complaints, CI MS #22045, CI MS #22062, CI MS #22065, CI MS #22066, CI MS #22089, CI MS #22090 and CI MS #22119 from 7/17/23 through 7/20/23. 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 requirements at M. The SA investigated CI MS #22062 for misappropriation of property, CI MS #22065 for call lights not answered timely, staffing, CI MS #22045 for residents left wet, misappropriation of property, residents with body odor, physical environment, CI MS #22089 for physical environment, CI MS #22119 for abuse and did not cite any deficiencies. The SA investigated CI MS #22090 for services not provided and Neglect and CI MS #22066 for staffing, physical environment and neglect and cited M 500 and M 615. At the time of survey, the facility had a census of 102 residents and was licensed for 113 beds.	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;	M 500		8/20/23

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M 500	Continued From page 1 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 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	M 500		

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M 500	Continued From page 2	M 500		

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 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

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M 500	Continued From page 3 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 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	M 500		

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M 500	Continued From page 4 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 II Based on interview, observations, record review and policy/procedure review, the facility failed to protect four (4) of ten (10) residents, Resident #1, Resident #2, Resident #3 and Resident #4, from neglect as evidenced by Resident #1 did not receive wound treatments on 7/8/23, 7/9/23, 7/10/23 and on 7/17/23 and Resident #2, Resident #3, Resident #4 did not receive their pressure sore treatments on 7/17/23. Findings include: Record review of the facility's policy/procedure for "Abuse, Neglect, Exploitation & Misappropriation", last revised 11/16/2022, revealed "Neglect is the failure of the center, it's employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress." Interview at 10:00 AM on 7/18/23, with the Director of Nurses (DON) and Administrator, the DON stated that Resident #1 is the resident that went to the wound care center on 7/11/23 and had a dressing on his wound dated 7/7/23. She stated that the wound care clinic contacted her letting her know the date on the dressing and that Resident #1 is being sent to the Emergency	M 500	On 7/18/23 the Director of Clinical Services interviewed interviewable residents with orders for wound treatments to determine if there were any other residents with allegations of neglect. Based on the allegations of neglect for resident #1, #2, # 3, and # 4, Registered Nurse # 2 was terminated on 7/18/23. Residents # 1, #2, # 3, and # 4 were assessed by Director of Clinical Services on 7/18/23 with no adverse findings. Current residents with wounds/treatment orders have the potential to be affected. Abuse and Neglect education was initiated by Executive Director (ED)/Director of Clinical Services (DCS) on 7/18/23 with current staff and will be completed by 8/15/23. Education with the Executive Director (ED) and Director of Clinical Services (DCS) on 8/4/23 by Regional Director of Clinical Services (RDCS) on Abuse and Neglect with emphasis on ensuring residents with wounds/treatment orders are completed as ordered. Newly hired staff will be educated by the Director of Clinical Services on the policies and procedures that govern resident abuse and neglect, specifically to include following physician orders, resident care plans and	

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M 500	Continued From page 5 Room (ER) at the local hospital for evaluation. He stayed overnight and returned to the facility on 7/12/23. The DON stated the wound care clinic said something about Resident #1's antibiotic therapy. They had called us with culture results and our Nurse Practitioner (NP) ordered Bactrim DS times 10 days. We were training a new treatment nurse, Registered Nurse (RN) #2 on those days. The DON stated RN#2 finally admitted during the investigation that she didn't do the wound care. During this interview, the DON stated that RN#2 was in the facility. The facility was about to suspend or terminate her employment due to the new allegation of wound care not being completed the day before. The Administrator revealed he went to visit Resident #1 this morning and Resident #1 stated his wound care was not done on 7/17/23. He stated he went and let the DON know what Resident #1 had said. He then went to talk to Licensed Practical Nurse (LPN) #1 who was doing treatments on 7/18/23. She told him that when she did wound care on Resident #1 this AM that the dressing was not dated and Resident #1 stated his wound care was not done on 7/17/23. Interview with LPN #1 on 7/18/23 at 10:30 AM, revealed there were other residents that had dressings dated for 7/16/23 and not 7/17/23 as she anticipated she would see on the morning of 7/18/23. The SA obtained a list of residents that LPN #1 had performed the 7/18/23 wound care for and had on old dressings that were dated 7/16/23. That list revealed that Resident #1 and Resident #2's dressings were not dated. These residents have a Brief Interview for Mental status (BIMS) score above 10 and are interviewable. They told LPN #1 their wound care was not done on 7/17/23. Resident #3 and Resident #4's wound dressings were dated 7/16/23.	M 500	administering wound care. A Quality Assurance Improvement (QAPI) meeting was held on 7/21/2023 to ensure the prevention of abuse and neglect by staff education and interviews with residents and staff. The Director of Clinical Services, Unit Managers, and Social Worker will conduct Quality Monitoring initiating on 7/24/2023, five (5) resident interviews per week for two (2) weeks, three (3) resident interviews per week for two (2) weeks, and then three (3) resident interviews per month for six (6) months to ensure the prevention of abuse and neglect. Staff education will be completed monthly beginning on 8/10/2023 to the policies and procedures that govern abuse and neglect. On 8/15/2023 we will conduct a QAPI meeting to review our findings from our Quality Monitoring to ensure our solution is sustained. We will review all findings from our Quality Monitoring on the third Thursday of each month during the QAPI meeting by the QAPI Committee in the monthly meeting for six (6) months to ensure our solutions are sustained.	

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M 500	Continued From page 6 Interview with RN #2 on 7/18/23 at 11:10 AM, revealed she began employment at this facility on 7/7/23. She was to "shadow" the treatment nurse over the weekend of 7/8/23, 7/9/23, and 7/10/23. She stated she was hired as the RN treatment nurse. She would do measurements and assessments of wounds weekly. She was responsible for giving the weekly measurements to the DON for the weekly wound log. She stated she has done treatments in other facilities. She stated she was becoming familiar with the supplies used by this facility, getting familiar with their computer system and that she was "assisting" the weekend treatment nurse doing treatments. "On 7/9/23, I did treatments for ½ the day. On 7/10/23, Sunday, I came in around 5:00 PM that day. The treatment nurse here that day had to leave early. The DON was in the facility and did treatments until I could get here." She stated, "On 7/10/23, I did not do treatments on him (Resident #1). I was the treatment nurse the day. My initials are not on the Treatment Administration Record (TAR). I didn't chart any treatments for Monday due to a computer problem." She then stated, "It was a couple (of treatments) I didn't do that Monday. Yes, I was the treatment nurse yesterday (7/17/23). I came in at 10:15 AM on 7/17/23. I went in as lunch was being served. Resident #1 said to wait for him to eat. I missed the time when the Certified Nurse Aides (CNA) were doing rounds for incontinent care. They help with positioning for him and other residents. His treatment didn't get done yesterday. I did not let anyone know. It was a lack of communication on my part." Regarding Resident #4, she stated, " I did not do the treatment to his right hip because he said the last dressing fell off. There was a dressing on it. He said there was an extra dressing in his room, and	M 500		

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M 500	Continued From page 7	M 500		

they put it on his wound. He didn't say who "they" were so I didn't redo the treatment." Regarding Resident #2, she stated, "I did not do her treatment yesterday. I was going to get the CNA's to help me with positioning. I never did. I was going to wait to go with them on their incontinent rounds and I forgot." She then confirmed, "I didn't tell anyone I had not done the treatments. I did not ask for help from another nurse."

Resident #1

Interview with Resident #1 on 7/18/23 at 10:45 AM, revealed that he did not have wound care performed on 7/17/23. He also confirmed that on the "weekend before", his wound care was not done for four (4) days. He confirmed the dates were 7/8/23, 7/9/23, and 7/10/23. He stated he went to the wound care clinic on 7/11/23, got his wound care done while at the clinic then was sent to the ER and admitted to the hospital overnight.

Record review of the Admission Record revealed the facility admitted Resident #1 on 8/25/22 with diagnoses including Peripheral Vascular Disease, Non-pressure chronic ulcer of unspecified heel and midfoot with unspecified severity and Non-pressure chronic ulcer of unspecified part of left lower leg with unspecified severity.

Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/11/23 revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating Resident #1 was cognitively intact.

Resident #2

Interview with Resident #2 on 7/18/23 at 10:40

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M 500	Continued From page 8 AM, she revealed that the "new treatment nurse" came into her room yesterday, told Resident #2 she'd be back to do her wound care and never returned. Resident #2 confirmed that her wound care did not get done yesterday. She stated the new treatment nurse had performed her wound care before and has not had a problem with her until yesterday. Record review of Resident #2's Admission Record revealed an admit date of 3/13/23. She admitted with diagnoses including Pressure Ulcer of Sacral Region, Stage 4, Pressure Ulcer of Right Buttock, Stage 2 and Pressure Ulcer of Left Buttock, Stage 4. Record review of the MDS with an ARD of 6/12/23 revealed a BIMS score of 15 which indicated Resident #2 was cognitively intact. Resident #4 Interview with Resident #4 on 7/18/23 at 2:00 PM, revealed that his wound care was not performed on 7/17/23. He stated that his wound care has been performed daily until "yesterday". He said he asked staff several times on 7/17/23 if the treatment nurse was in the facility and staff would tell him yes but he never saw her or spoke to her. "I waited up until 10:00 PM last night on RN #2 but I went on to bed and figured she'd wake me up to do the treatment. I never spoke to RN #2 yesterday. I never even saw her." Record review of the Admission Record revealed Resident #4 was admitted to the facility on 7/13/23 with diagnoses that included Pressure ulcer of right hip, Stage 4. Record review of Resident #4's Admission MDS	M 500		

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M 500	Continued From page 9 with an ARD of 7/24/23, Section C revealed a BIMS score of 12, indicating moderately impaired cognition. Resident #3 Interview on 7/18/23 at 3:15 PM, with Resident #3, he stated that his treatment was not done yesterday. Record review of the Admission Record revealed Resident #3 was admitted to the facility on 8/5/21 with diagnoses including Pressure Ulcer of other site, Stage 3. Record review of the MDS with an ARD of 6/22/23 revealed a BIMS score of 15 which indicated Resident #3 was cognitively intact.	M 500		
M 615	45.21.3 Pressure sores Pressure sores. Residents with a pressure sore shall receive necessary treatment and service to promote healing and prevent the development of new pressure sores. Residents without pressure sores will not develop pressure sores unless the residents' clinical condition indicates they were unavoidable. This Statute is not met as evidenced by: Level II Based on interviews, observations, record reviews and policy/procedure review, the facility failed to ensure that three (3) of 10 sampled residents received the necessary treatment and services, consistent with professional standards of practice for pressure ulcers, as evidence by Resident #2, Resident #3, Resident #4 did not	M 615	Residents #2, #3, and #4 Physician/Nurse Practitioner were notified that their residents wound care/treatment orders were not carried out as ordered on 7/18/23. Based on the allegations the wound care/treatment orders were not followed and treatments were not carried out as ordered for resident #2, # 3, and # 4, Registered Nurse # 2 was terminated	8/20/23

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M 615	Continued From page 10 receive their pressure sore treatments on 7/17/23. Findings include: Record review of the facility's policy/procedure for "Skin and Wound", with a revision date of 1/24/2022 revealed "Policy: To provide a system for identifying risk, and implementing resident centered interventions to promote skin health, prevention and healing of pressure ulcers..." Licensed Practical Nurse (LPN) #1 reported during an interview on 7/18/23 at 10:30 AM, there were other residents that had dressings dated for 7/16/23 and not 7/17/23 as she anticipated she would see on the morning of 7/18/23. The SA obtained a list of residents that LPN #1 had performed the 7/18/23 wound care for and had on old dressings that were dated 7/16/23. The list indicated that Resident #2's wound dressings were not dated current. Resident # 2 told LPN #1 wound care was not done on 7/17/23. Resident #3 and Resident #4's wound care dressings were dated 7/16/23. Resident #2 During an observation and interview with Resident #2 on 7/18/23 at 10:40 AM, revealed that the "new treatment nurse" came into her room yesterday, told Resident #2 she'd be back to do her wound care and never returned. Resident #2 confirmed that her wound care did not get done yesterday. She stated the new treatment nurse had performed her wound care before and has not had a problem with her until yesterday.	M 615	on 7/18/23. The Director of Clinical Services re-assessed all pressure sores and updated treatment orders and care plans as needed on 7/18/23. All residents have the potential to be affected by this deficient practice. A Quality Review of current residents with pressure ulcers was conducted by the Director of Clinical Services/Unit Manager on 7/18/23 and 7/19/23 to ensure treatment and services are provided to prevent the development or worsening of pressure ulcers and to promote wound healing. A Root Cause Analysis (RCA) was completed on 7/21/2023 by the Quality Assurance Performance Improvement (QAPI) Committee on ensuring all residents with pressure ulcers/wound treatment orders are being carried out per physician order. We identified one Registered Nurse did not follow physician orders and/or carry out ordered treatments to resident #2, #3, and #4. She was terminated on 7/18/2023. On 7/18/23, the Director of Clinical Services and Treatment nurse began education with nursing staff on the components of this regulation with emphasis on providing necessary treatment for prevention and healing of pressure ulcers. Newly hired licensed nurses will be educated by the Director of Clinical Services on the policies and procedures that govern care plans, following physician orders, and wound care. A Quality Assurance Improvement (QAPI)	

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M 615	Continued From page 11 Observations of wound care with RN #1 on 7/19/23 at 10:45 AM, revealed multiple wounds. There are treatments for 4 wounds on her sacral, coccyx and bilateral buttocks but upon observation, there are 3 wounds noted. This was confirmed by RN #1. The wound on the coccyx is a Stage 4. It measures 5.0 cm L (centimeters/length) x (by) 6.0 cm W (width) x 7.4 cm D (depth). The wound bed is beefy in color. The right buttock inferior is a Stage 2 and measures 14.0 cm L x 8.7 cm W x 0.0 cm D. The left buttock wound is a Stage 2 and measures 4.2 cm L x 3.4 cm W x 0.0 cm D. She stated she is not going to do the treatment to the left heel due to that area is healed. She stated she is going to talk to the Medical Doctor (MD) or Nurse Practitioner (NP) to get the order discontinued due to it being healed at this time. She stated it was a Deep Tissue Injury that had a treatment begin on 7/4/23. Interview with RN #2 on 7/18/23 at 11:10 AM, stated, "I did not do her treatment yesterday. She gets Betadine on her foot, I believe. I was going to heal her wound today. I was going to get the CNA's to help me with positioning. I never did. I was going to wait to go with them on their incontinent rounds and I forgot." Record review of the wound care orders were to "Clean Stage 4 to coccyx with wound cleanser or NS (normal saline), pat dry with 4x4 gauze, pack wound with wet-dry dakins kerlix, cover with dry dressing daily and PRN (as needed). Cleanse Stage 4 to left buttock/sacrum with wound cleanser or NS (Normal Saline), pat dry with 4x4 gauze, apply CA+ alg AG (Calcium Alginate), cover with dry dressing daily and PRN (as needed). Cleanse Stage 2 to right buttock (inferior) with wound cleanser or NS, pat dry with	M 615	meeting was held on 7/21/2023 to ensure pressure ulcer/wound care is being provided for per physician orders. On 7/24/2023 the facility Director of Clinical Services (DCS), and Unit Managers will conduct ongoing quality monitoring of residents with wounds/treatment orders to ensure the treatments are being carried out per physician orders, two (2) times weekly for four (4) weeks, then one (1) time a week for four (4) weeks, then monthly for six (6) months to ensure the wounds/treatment are being carried out per physician orders. Staff education will be completed monthly beginning on 8/10/2023 to the policies and procedures that govern care plans, following physician orders, and wound care. On 8/15/2023 we will conduct a QAPI meeting to review our findings from our Quality Monitoring to ensure our solution is sustained. We will review all findings from our Quality Monitoring on the third Thursday of each month during the QAPI meeting by the QAPI Committee in the monthly meeting for six (6) months to ensure our solutions are sustained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49WM	A. BUILDING: _____ B. WING _____	C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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M 615	Continued From page 12	M 615		

4x4 gauze, apply CA+ alg AG, cover with dry dressing daily and PRN.

Record review of Resident #2's Admission Record revealed an admit date of 3/13/23. She admitted with diagnoses including Pressure Ulcer of Sacral Region, Stage 4, Pressure Ulcer of Right Buttock, Stage 2 and Pressure Ulcer of Left Buttock, Stage 4.

Record review of the MDS with an ARD of 6/12/23 revealed a BIMS score of 15 which indicated Resident #2 was cognitively intact.

Resident #3

Observation and interview on 7/18/23 at 3:15 PM, with Resident #3 stated that his treatment was not done yesterday. Wound care observation revealed the wound is a Stage 3 on his left lateral foot. The measurements observed by the SA were 0.5 cm L x 0.3 cm W x 0.0 cm D.

Record review of the Admission Record revealed Resident #3 was admitted to the facility on 8/5/21 with diagnoses that included Stage 3 pressure ulcer to left lateral distal foot.

Record review of the MDS with an ARD of 6/22/23 revealed a BIMS score of 15 which indicated Resident #3 was cognitively intact.

Record review of the Order Summary Report with active orders as of 7/20/23 revealed "Wound Care: Cleanse stage 3 to left lateral distal foot with wound cleanser or NS, Pat dry with 4x4 gauze, apply calcium alg AG, and bordered dressing daily and PRN every day shift."

Resident #4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49WM	A. BUILDING: _____ B. WING _____	C 07/20/2023

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M 615	Continued From page 13 RN #2 stated in an interview on 7/18/23 at 11:10 AM, regarding Resident #4, "I did the wound care on his toe on the left foot. The wound under his arm is healed and I don't think there is a treatment ordered. I did not do the treatment to his right hip because he said the last dressing fell off. There was a dressing on it. He said there was an extra dressing in his room, and they put it on his wound. He didn't say who 'they' were. So, I didn't redo the treatment." Observations and interview on 7/18/23 at 2:00 PM, of Resident #4's wound care performed by RN#1 being assisted by RN #3 revealed Resident #4 has multiple wounds. The right hip Stage 4 pressure ulcer measured 5.0 cm L x 5.7 cm W with tunneling between 2:00-3:00 o'clock measured 1.4 cm D. The wound on his left medial foot is below his great toe measured 3.8 cm L x 2.4 cm W x 0.0 cm D. Hyper granulation is noted. Resident #4 revealed that his wound care was not performed on 7/17/23. He said he asked staff several times on 7/17/23 if the treatment nurse was in the facility and staff would tell him yes but he never saw her or spoke to her. "I waited up until 10:00 PM last night on RN #2 but I went on to bed and figured she'd wake me up to do the treatment. I never spoke to RN #2 yesterday. I never even saw her." Record review of the Order Summary Report with active orders as of 07/20/23 revealed "Wound Care: Clean Stage IV (4) abrasion to Right Trochanter with wound cleanser or normal saline and gauze daily: dry the peri-wound skin and place skin proctetant...Place santyl on slough of wound base;Dampen non-stretch gauze with 1/4 strength Dakin's solution and fan to cover wound bed ONLY;fill the volume of the wound with	M 615		

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M 615	Continued From page 14 FLUFFED (not stuffed) with the least amount of gauge. Cover with ABD pad and secure. Wound Care: Cleanse abrasion to left medial foot below great toe with wound cleanser or normal saline daily and PRN;cover with meplix dressing every day shift..." Record review of the Admission Record revealed Resident #4 was admitted to the facility on 7/13/23 with diagnoses that included Pressure ulcer of right hip, Stage 4. Record review of the MDS with an ARD of 7/24/23 revealed a BIMS score of 12 which indicated Resident #4 had moderate cognitive impairment.	M 615		