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
	44WP	A. BUILDING: _____ B. WING _____	C 01/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WINDSOR PLACE	81 WINDSOR BOULEVARD COLUMBUS, MS 39702

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M 500 SS=D	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 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;	M 500		2/9/21

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M 500	Continued From page 1 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 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	M 500		

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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 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

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M 500	Continued From page 3 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: Based on record review, facility policy review and staff interviews, the facility failed to prevent verbal abuse to one (1) of five (5) residents interviewed. Findings include: M500 Facility policy titled, "Abuse, Neglect, Exploitation, and the Vulnerable Adults Act Policy", dated 8/29/2016, reveals, "It is the policy of this facility that residents and patients are to be treated with dignity and respect at all times under any circumstance. Mistreatment in the from of verbal or physical abuse of any nature will not be tolerated." An interview on 1/27/2021 at 12:30 PM, with the Director of Nurses (DON), revealed the facility	M 500	1. Resident # 1 was assessed on 5/10/20 by the Charge Nurse (registered nurse) on duty. No negative findings noted. Body audit was performed by the Charge Nurse (registered nurse) and treatment nurse (licensed practical nurse) on 5/11/20 with no negative findings. Certified Nursing Assistant #1 was suspended on 5/10/20 by the Director of Nursing and terminated on 5/11/20 by the Director of Nursing. 2. All Residents in Certified Nursing Assistant #1□s care were interviewed by Assistant Director of Nursing and Director of Nursing on 5/11/2020 with no negative findings noted. 3. One Hundred percent (100%) of all	

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M 500	Continued From page 4 had reported an incident of verbal abuse of Resident #1 that occurred on 5/9/ 2020 to the State Agency. Stated Certified Nursing Assistant (CNA) #1 wrote a note to Resident #1. The note read, "It is time for bed you live here in this nursing home. I am not going to argue with you if you are not going to comply with me then I am going to just pick you up and put you in the bed forcefully. No one is coming for you now get up and get in this bed or I'm going to get really rude." Stated CNA #1admitted she wrote the note. Stated CNA #1 was terminated. Stated the incident was investigated and in-services of all employees were immediately started. Review of the letter written on a paper towel to Resident #1 read as follows: "It is time for bed you live here in this nursing home. I am not going to argue with you if you are not going to comply with me then I am going to just pick you up and put you in the bed forcefully. No one is coming for you now get up and get in this bed or I'm going to get really rude." Review of facility's investigation revealed on 5/10/2020, a hand written note was found on Resident #1's bedside table. This was immediately reported to the Nursing Supervisor. The Director of Nurses was notified. The staff working with Resident #1 during the previous shifts were notified not to return to work until meeting with Director of Nursing. Resident #1 was interviewed and investigation revealed she had no recollection of the letter or anybody being rude to her. The investigation revealed CNA #1 admitted that she had left the note in the room. CNA #1 submitted a handwritten statement as follows,"'I did write a note to (Proper Name) Resident #1 to get her to go to bed because she was not going to let me put her in the bed. I did	M 500	staff were in-serviced by the Staff Development Coordinator (registered nurse) on abuse, neglect, resident rights, and care of dementia residents. In-service was initiated on 5/11/20 by the Staff Development Coordinator (registered nurse) and completed on 5/26/2020 by the Staff Development Coordinator (registered nurse). All new employees will be in-serviced by the Staff Development Coordinator (registered nurse) upon hire prior to working with any resident. 4. On 5/11/2020 the Quality Assurance Registered Nurse, Assistant Director of Nursing, and the Director of Nursing initiated plans for monitoring for abuse and neglect. Random interviews held with five (5) residents three (3) x weekly for two (2) weeks; then three (3) residents two (2) x weekly for two (2) weeks; then three (3) residents weekly x four (4) weeks; then three (3) residents monthly x four (4) month. Results of audits were reported to and reviewed by the Quality Assurance Performance and Improvement Committee monthly for six (6) months; and completed on 10/30/2020. No reports of any type of abuse or neglect during the six (6) months of audits conducted with randomly selected residents.	

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say that I was going to forcefully put her in the bed but only to get her to comply with me. I understand that I shouldn't have used the word that I did and I take full responsibility for my actions." Investigation report reveals CNA #1 was terminated at that time.

Record review of investigation reveals a body audit on Resident #1 was performed on 5/11/2020. No bruises or skin tears were noted and skin was intact.

Record review of investigation reveals DON interviewed all residents in CNA #1's care and "no residents reported any problems with care or having any trouble or concerns with the staff that provide care to them."

Review of CNA #1's timecard reveals employee clocked in on 5/9/2020 at 3:19 PM and clocked out for meal from 7:00 PM till 7:30 PM and clocked out at end of shift at 11:02 PM. No other dates after that were clocked on report. Review of facility staff's schedule revealed CNA #1 was scheduled to work on 5/9/2020 from 3PM till 11 PM. No other dates after that date were worked. Record review of Daily Assignment Sheet reveals on 5/9/2020 3-11 shift, CNA #1 was assigned to Care Team #1-A with room numbers 300 - 307. Review of daily census room list dated 5/9/2020, revealed Resident #1 was assigned to room 307B. Review of assignment revealed CNA #1 was assigned to 12 residents on 5/9/2020 on the 3 PM - 11 PM shift. Review of facility's staffing for that date revealed sufficient staff present.

Record review of Employee Status/Payroll Change Report revealed CNA #1's last day to work was 5/9/2020, she was suspended on 5/10/2020, and was terminated related to

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M 500	Continued From page 6 disciplinary action on 5/11/2020. Review of CNA #1's personnel record reveals she was hired by the facility on 12/11/2017. On hire training related to Abuse and Neglect and Residents Rights was given and employee signed forms acknowledging she received training in these areas on 12/11/2017. Nurse Aide Registry Verification reveals the employee's certification date was 3/15/2011 with an expiration date of 3/31/2021. Review of MSDH Criminal History Record Check dated November 22, 2017, revealed there were "no violations that would prevent (Proper Name) (CNA #1) from working with patients, residents or clients being served by a licensed hospital, nursing home, personal care home, home health agency or hospice." Record review of Abuse and Neglect in-service dated 3/27/2020 reveals CNA #1 attended the in-service and signed the attendance log. Review of record reveals incident was reported to the State Agency and the AG office. The State Agency attempted to contact CNA #1 three times by phone and left message each time. CNA #1 did not return call. Review of record reveals Resident #1 was admitted to the facility on 4/25/2017 with diagnoses of Muscle Weakness, Paroxysmal Atrial Fibrillation, Major Depressive Disorder, Anxiety Disorder, Unspecified Dementia with Behavioral Disturbance, Acute on Chronic Combined Systolic and Diastolic Heart Failure. Resident's Brief Interview for Mental Status (BIMS) score of 15 on Minimum Data Set (MDS) on 3/23/2020, indicating resident was cognitively intact. MDS dated 10/1/2020 revealed a BIMS	M 500		

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M 500	Continued From page 7 score of 8, indicating moderate cognitive impairment. Unable to interview Jacqueline Brumley, Resident due to her passing away on 11/9/2020. Death Certificate reviewed. Cause of death listed as Cardio Pulmonary Arrest, Acute on Chronic Heart Failure, Advanced Dementia, and Pneumonia. An interview with the DON on 1/28/2021 at 11:45 AM revealed the facility investigated the allegation of abuse. Stated CNA #1 admitted she had written the letter that was found on Resident #1's bedside table. The DON stated she suspended and terminated CNA #1 immediately. Stated the staff was in-serviced on abuse and neglect. Confirmed the facility failed to prevent the verbal abuse to a resident. An interview on 1/28/2021 at 1:30 PM, with the Administrator, revealed once the allegation of abuse was made, the employee did not work at the facility. Stated CNA #1 admitted she wrote the note found on Resident #1's bedside table. Stated her last shift to work was 3 PM - 11 PM on 5/9/2020, and when the note was discovered the next morning on 5/10/2020, employee was notified and suspended and told to not report to work until morning of 5/11/2020 for a meeting with the DON. Stated the employee, CNA #1, was terminated on 5/11/2020. Administrator confirmed the facility failed to prevent the verbal abuse to a resident.	M 500		