STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255257	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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was conducted by the State Agency (SA) on 1/27/21 through 1/28/21. The facility was found to be in compliance with 42 CFR 483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. The census at the time of the survey was 84. The State Agency (SA) investigated CI MS #17477 and CI MS #16995 at the facility from 1/27/21 through 1/28/21. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid. The SA substantiated complaint MS CI #16995 and cited F600. CI MS #17477 was not subatantiated for abuse. The facility had a census of 84 at the time of the complaint survey, with a license for 140 bed capacity.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or	F 600		2/9/21

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

Electronically Signed | 02/11/2021

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F 600	Continued From page 1 physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT 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: 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 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	F 600	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 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	

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F 600	Continued From page 2 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 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."	F 600	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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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 staff assignment reveals CNA #1 was assigned to 12 residents on 5/9/2020 on the 3PM - 11PM 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 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

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F 600	Continued From page 4	F 600		

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 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.

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F 600	Continued From page 5 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.	F 600		