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 10/28/2021

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 000	Initial Comments The State Agency (SA) conducted an annual recertification survey and a complaint survey for MS00018215 related to quality of care/treatment and residents safety and MS00018227 related to a fall with injury at the facility from 10/25/21 through 10/28/21. During the survey the SA found that the facility was not in compliance with The Minimum Standards for Instutions for the Aged or Infirm and substantiated MS00018215 and cited M640 for Accidents at a Level III. Additional tags were cited related to the recertification survey at M815 at a Level II related to safe food handling. MS00018227 was unsubstainiated. The facility held a license for 140 beds and had a census of 117 at the time of the survey.	M 000		
M 640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This Statute is not met as evidenced by: Level III Based on observation, staff and family interviews, record review and facility policy review, the facility failed to provide increased supervision for a resident who had sustained ten (10) falls with two (2) resulting in major injuries that included a Subarachnoid Hemorrhage and a fractured hip from 8/31/21 to 10/26/21 for one (1) of five (5) residents reviewed for falls, Resident #111. Findings include:	M 640	Upon return from hospital on November 11,2021, Resident #111□s previous falls and care plan were reviewed by admitting nurse, Minimum Data Set nurse, Director of Nursing, and Assistant Director of Nursing. Appropriate fall interventions have been identified and implemented based on resident□s current needs, cognitive status, and level of care. Resident□s certified nurse assistant assignment sheet updated by Alzheimer's Unit director on November 3, 2021. Phone	11/18/21

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M 640	Continued From page 1 Review of the facility policy titled, "Fall Prevention Policy", with a revision date of 04-01 revealed "Policy: It is the policy of this facility that each resident will be assessed upon admission, re-admission, quarterly, and annually or with a significant change for their fall risk potential. Procedure:...2 incorporate individualized measures and interventions into the resident's care plan for residents who are identified to be at risk for falls..." An observation on 10/25/21at 3:30 PM, revealed Resident #111 sitting on her bed with the Assistant Director of Nursing (ADON) present in the room. As soon as this surveyor came into the room the resident stood up, placed her hands on her walker and began trying to have a conversation. During the conversation, after the first few words, the resident's speech was garbled and not understandable. An interview, on 10/25/21 at 6:41 PM, with Registered Nurse (RN) #1 revealed Resident #111 fell in her bathroom because she had gotten up unassisted and caused a hip fracture and four to six weeks prior, she fell in the Alzheimer's Unit and caused a head injury that she thought was a bleed. Record review of Resident #111's Incident Report dated 8/31/21 at 11:45 PM revealed in "Narrative of Incident and description of injuries. Resident was found on the floor beside the bed. Attempted to get resident up out of the floor and resident became combative with this nurse attempting to hit and screaming. Cursing at this nurse. Resident got herself out of the floor. Moves all extremities well. No complaint of pain voiced. Refused all vital signs (v/s) and care at this time...	M 640	care plan conference held with interdisciplinary team and resident□s responsible party on November 5, 2021. All residents with a history of falls and/or risk of falls have the potential to be affected. One hundred percent (100%) review of all residents□ careplans was initiated on November 1, 2021, and completed on November 8, 2021, by the Director of Nursing, Assistant Director of Nursing, Quality Assurance Nurse, Minimum Data Set/Careplan Nurses and Unit Managers (Registered Nurses) to ensure each resident had a fall careplan with appropriate interventions for resident□s current needs, cognitive status and level of care. All licensed nurses were in-serviced on Free of Accidents Hazards/Supervision/Devices regarding fall prevention measures, utilization of resident centered interventions and documentation. In-service initiated on October 29, 2021, and completed on November 18, 2021, by Registered Nurse/Administrator from outside facility. All new employees will be in-serviced by the Staff Development Coordinator (Registered Nurse) while in orientation prior to working with any resident. Falls to be reviewed during morning clinical meetings Monday through Friday beginning October 29, 2021. Also beginning October 30, 2021, falls will be reviewed by Registered Nurse/Licensed Practical Nurse supervisors on Saturday	

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M 640	Continued From page 2 Immediate Action's Taken: Attempted to observe resident for injuries and assist from floor. Unable to do either at this time." Record review of the Resident #111's Incident Report dated 9/05/21 at 01:51 AM revealed, "Resident was found on floor next to bed. Resident was laying on right side legs wrapped up in bed spread, pillow was on floor near head, resident was asleep, aroused when spoke to. It appears that resident rolled out of bed when turning over. She then turned onto knees and pulled self up holding on to staff. Ambulated to bathroom and back to bed without difficulty. No apparent injuries." Record review of the Resident #111's Incident Report dated 9/08/21 at 01:40 PM revealed, " Resident was attempting to sit down in a dining room chair. She sat on the arm and slid to the floor. Did not hit head; moves all extremities." Record review of the Resident #111's Incident Report dated 9/10/21 at 02:55 PM revealed, "Resident was in the dining area attempting to get into the snack cart when redirected by Certified Nursing Assistant (CNA) , resident became belligerent and attempted to grab the portable kitchen barrier causing herself to lose balance and falling to the floor. Resident did not hit her head. No injuries noted." Record review of the fall Incident Report, dated 9/12/21 at 05:55 AM, revealed Resident #111 was leaning over to "pick" at the floor when she lost her balance and went down on her bottom. The nurse assessed for injuries and assisted resident back up and placed in chair with 2 persons assist. Bruise noted to right side. Resident would not allow the nurse to measure area."	M 640	and Sunday to ensure root cause of fall is identified and appropriate interventions are added to the careplan. These clinical reviews will continue routinely going forward. Facility fall prevention policy was reviewed on November 10, 2021, by the Quality Assurance and Performance Improvement Committee with no needed changes or revisions made. On October 29, 2021, the Director of Nursing and/or Assistant Director of Nursing initiated plans of monitoring falls and updating of the fall careplan after a fall for new and appropriate interventions. Audits of three (3) falls weekly x four (4) weeks beginning October 29, 2021, then two (2) falls weekly x two (2) weeks then three (3) falls monthly x six (6) months. Any concerns will be addressed. All findings will be reported to the Quality Assurance Performance Improvement Committee monthly beginning November 10, 2021, and continue for the next six (6) months and as needed for any recommendations, revisions, and/or resolutions.	

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M 640	Continued From page 3 Record review of the Incident Report, dated 9/13/21 at 04:15 PM, revealed, "nurse was called to room by CNA; resident found on floor between door and roommates bed; c/o pain to head and L (left) cheek; egg size raised area noted to left/back of head; no redness noted to face; able to move all extremities without difficulty; neuro check within normal limits (WNL); assisted from floor; order obtained to send resident to ER for evaluation; ambulance called at approximately 4:30 PM; ambulance arrived at approximately 4:45 PM to transport resident to ER; Responsible Party (RP) notified." Record review of the hospital History and Physical dated 9/14/21 revealed the resident was admitted to the hospital with an admitting diagnosis of "Subarachnoid hematoma." Record review of a Physician's Order dated 9/24/21 on hospital return revealed, "Admit to skilled services for intracranial hemorrhage w(with)/new peg tube placement." Record review of the Incident Report dated 10/03/21 at 03:01 PM, revealed Resident #111 had gotten up from bed. She was yelling/crying out. Upon entering room, she was found on floor in bathroom. Her head was against the bathroom wall near the toilet. Her legs were towards door. She was not wearing shoes but did have on grip socks. There was feces on the toilet and on resident. Injuries noted as "right hip pain" and disposition noted as "hospital admission." Record review of a Physician's Order dated 10/3/21 at 3 PM revealed, "Send to ER for evaluation related to fall with right hip pain." Record review of the hospital Admission History and Physical dated 10/3/21 revealed the resident was admitted to the hospital with an admitting	M 640		

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diagnosis of "fracture at her right hip." Record review of a Physician's Order dated 10/8/21, for Resident #111's re-admission to the facility revealed, "Admit to skilled services Right Hip fracture repair with/previous Intracranial Hemorrhage (ICH) and recent peg (Percutaneous Endoscopic Gastrostomy) tube placement."

Record review of the Incident Report dated 10/19/21 at 06:40 PM, revealed Resident #111 self-propelled her wheelchair in the foyer in front of the couch and was trying to transfer unassisted and slid to her knees. She sustained a superficial skin tear to the left knee measuring 2.0 cm(centimeters) X 1.0 cm."

Record review of Resident #111's Incident Report dated 10/26/21 at 05:46 PM, revealed "This writer was sitting at desk when I heard a loud bang. Upon entering room resident was lying flat on her back with overbed table underneath her head. Her legs were stretched out straight towards foot of bed. She had gotten up from the bed unassisted. She was wearing shoes. No injury noted. Transfered to the ER for an evaluation."

A telephone interview, on 10/26/21 at 4:20 PM, with Resident #111's Responsible Party (RP) revealed to the State Agency (SA) that the facility staff told the family they could stay with Resident #111 24/7 or hire a sitter. The RP stated that they would not have put her in the nursing home if they could afford a sitter. She stated that she did not feel like they were watching her as close as they should.

An interview, with RN #1 on 10/27/21 at 8:30 AM, revealed that Resident #111 went to the local hospital after her fall in September 2021 that

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caused a head injury and was transferred from there to another hospital. RN #1 revealed that Resident #111 returned to the local hospital before she returned to the facility.

An interview, on 10/27/21at 9:00AM with RN #1 revealed the resident had a fall yesterday afternoon on 10/26/21 as she was getting out of bed and fell back and hit her head on the floor and she had to be admitted to the hospital.

An interview, on 10/27/21 at 2:25 PM, with Registered Nurse (RN) #1 revealed Resident #111 usually does not let us know when she needs something, we just have to ask or watch her. RN #1 stated that she has noticed if Resident #111 was fidgeting or squirming around she needed to go to the bathroom and she would ask her.

An interview, on 10/27/21 at 2:28 PM, with Certified Nursing Assistant (CNA) #1 revealed that the resident sometimes tells us when she needs something and sometimes, she doesn't. CNA #1 revealed that Resident #111 sometimes refuses care, such as baths or changing her, but when they go back in an hour or so she will agree.

An interview, on 10/28/21 at 9:43 AM with RN #1 revealed that they have not done a toileting program, because she has been in and out of the facility so much. RN#1 stated that after a fall, they try to get the Certified Nursing Assistants (CNA) posted outside Resident #111's door as much as they can. RN #1 stated that the CNAs know what they need to do because they are given verbal report that tells them any changes. RN #1 stated that the standard for checking on residents is every two hours, but we do not have it

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documented anywhere that shows we checked on Resident #111 more often. RN #1 confirmed that there should have been specific times to increase checks on Resident #111 and confirmed that they had not put into place any more frequent checks other than every two hours.

An interview, on 10/28/21 at 9:55 AM with Director of Nurses (DON) revealed that when Resident #
111 came back from the hospital after her last fall the Social Worker offered to find sitters that the family could pay for and asked the RP if they wanted to sit with her and they refused. The DON revealed they had put Resident #111's bed in the low position and were using a concave mattress. The DON revealed we cannot do a fall mat because it is a trip hazard. The DON confirmed that the facility failed to provide more frequent supervision checks on the resident after each fall and had every two hours supervision checks currently on Resident #111 and they failed to provide increased supervision to prevent further falls and said that the facility couldn't provide someone to sit with the resident because they just weren't able. The DON confirmed that the staff will bring her out to the desk at times and watch her but that they don't have anything documented to provide supervision more frequent than every two hours.

An interview, on 10/28/21 at 10:25 AM, with Licensed Practical Nurse (LPN) #1 revealed that there was a lot of one-on-one time spent with Resident #111 and she thinks that is the best defense for her.

An interview on, 10/28/21 at 10:28 AM with the Therapy Supervisor regarding Resident #111 revealed that they usually try to educate the

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family that staff will try to keep a closer eye on her and due to her stroke, her decision making is not to the best. The Therapy Supervisor revealed that they update the resident's family at the care plan meeting regarding her progress and therapy plan. Therapy supervisor revealed that therapy relays information about any changes in resident's plan of care to the nursing staff verbally. Therapy supervisor revealed that they have focused on strengthening for Resident # 111 due to her hip fracture, because she sometimes is not willing or does not understand.

Record review of the Face Sheet revealed Resident #111 was admitted to the facility on 8/23/21 with diagnoses which included Cerebral Vascular Accident (CVA), Trauma Subarachnoid Hemorrhage ; Cerebral Infarction, Encephalopathy, Dementia, Type 2 Diabetes mellitus, Major Depressive Disorder, Unspecified Cirrhosis of liver, Dysphagia, Cognitive Communication deficit, Thrombocytopenia, Alcohol abuse, Rheumatic multiple valve disease, Metabolic encephalopathy; Hypothyroidism; Chronic pain syndrome; Hyperlipidemia; Other abnormalities of gait and mobility; Anxiety; Encounter for attention to gastrostomy; Hypertension; Hypomagnesemia; Muscle weakness; Unspecified lack of coordination; Difficulty in walking; Anemia; Fracture of right femur; and Alzheimer's disease.

Record review of the Significant Change-Minimum Data Set (MDS) assessment dated 9/30/21 revealed the residents Brief Interview for Mental Status (BIMS) score as 99, indicating that the resident did not participate in the assessment or was unable to complete the interview due to severe cognitive ability.