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 _____	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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F 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 Medicare and Medicaid regulations and substantiated MS00018215 and cited F657 at a G level related to care plan revision and updates and F689 at a G level related to supervison and accidents. Additional tags were cited related to the recertification survey at F623 at a D level related to transfer/discharge notification, F640 at a D level related to a Minimum Data Set discharge assessment was not completed, F812 at an E level related to Dietary and F868 at a D level for Quality Assurance Program. MS00018227 was unsubstainiated. The facility held a license for 140 beds and had a census of 117 at the time of the survey.	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section;	F 623		11/18/21

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

Electronically Signed | 11/18/2021

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F 623	Continued From page 1	F 623		

and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how

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F 623	Continued From page 2	F 623		

to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate

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F 623	Continued From page 3 relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interviews, resident interview and record review, the facility failed to notify the Resident Representatative in writing of a transfer to the hospital for two (2) of four(4) residents reviewed. Resident # 56 and Resident # 111. Findings include: Record review of the facility Policy and Procedure titled "Notice of Facility Initiated Emergency Transfer" dated 10/28/21 revealed upon a facility initiated emergency transfer, it is the policy to provide transfer notice as soon as practicable to resident and resident representative to include the reason for the transfer, the effective date of the transfer, and location to which the resident is transferred. On 10/25/21 at 02:11 PM, an interview with Resident # 56 revealed she had one recent hospital stay because she was having breathing problems. On 10/26/21 at 02:10 PM, an interview with Social Services (SS) #2 revealed the Bed Hold Form was being sent to families and a call is made to inform families of a resident being transferred to the hospital, but no written notification is given to the Resident Representatiave (RR) with notification of the hospital transfer or reason for the transfer. On 10/27/21 at 08:27 AM, an interview with the Director of Nursing (DON), when asked by the Surveyor for a copy of Resident #56's Transfer	F 623	November 12, 2021, Resident #56 and Resident #111 Resident Representatives were notified that for potential future emergency transfers they will be mailed a written notice of the emergency transfer along with the verbal notification at the time of the transfer. No adverse effects were identified through the findings of the deficient practice. All residents that are transferred to acute settings have the potential to be affected. October 29, 2021, Staff Development Coordinator (Registered Nurse) in-serviced Social Services Department on Notice Requirements Before and Upon Transfer and/or Discharge to another setting. Copies of the written notifications of transfer will be kept in resident□s medical record. Social Services staff will send written notifications throughout the work week and will review weekend transfers on Mondays beginning November 1, 2021, and going forward, to ensure written notifications are mailed to the Resident Representative. October 28, 2021, Written Notification of Facility Initiated Emergency Transfers policy was developed by the Administrator and Director of Social Services and on November 10, 2021, approved by the Quality Assurance and Performance Improvement committee.	

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F 623	Continued From page 4 Notification Form, the DON revealed she was not aware of this form being completed by this facility, and she has not seen the form, but will provide information regarding it. Record review of the Physician's orders revealed orders to transfer Resident # 56 to the hospital on 6/6/21 and 7/21/21. Record review of Resident # 56's Minimum Data Set (MDS) for discharge and returns revealed a discharge MDS on 6/6/21, a return MDS on 6/11/21, a discharge MDS on 7/21/21 and a return MDS on 7/23/21. Record reviw of Resident #56's Face Sheet was admitted to the facility on 11/28/16 and has diagnoses that include Dysphagia, Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure, Schizophrenia, Bipolar and Diabetes. Record review of Resident #56's quarterly MDS with an with an Assessment Reference Date (ARD) of 8/31/21 revealed Resident #56 had a Brief Interview of Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. Resident #111 Record review Physician's Orders revealed resident #111 was hospitalized on 9/13/21 due to	F 623	Director of Social Services will audit the written notifications to Resident Representatives weekly for four (4) weeks beginning November 1, 2021, then monthly for five (5) months. All findings will be reported to the Quality Assurance Performance Improvement Committee monthly beginning November 10, 2021, and continue for the next five (5) months and as needed for any recommendations, revisions, and/or resolutions.	

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F 623	Continued From page 5 fall and was readmitted to the facility on 9/24/21 Record review of Physician's Orders dated 10/03/21 revealed Resident #111 was transferred to the hospital due to a fall with right hip pain and was re-admitted to the facility on 10/08/21. On 10/27/21 at 10:52 AM, an interview with Social Services (SS) #1 confirmed the facility is not sending a written notice when residents are transferred and admitted to the hospital. SS #1 revealed she interpreted the regulation requiring a written notification to be sent to the RR was only applicable when the resident was discharged from the facility and not expected to return to the facility.	F 623		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident	F 640		11/18/21

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F 640	Continued From page 6 contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and facility policy review, the facility failed to complete a discharge assessment for the Minimum Data Set (MDS) for one (1) of two (2) residents identified for resident assessments. Resident 1. Findings include: Review of the facility policy titled, "MDS 3.0	F 640	November 5, 2021, Minimum Data Set nurse completed and transmitted the missed May 17, 2021, discharge assessment on Resident #1. All residents discharged with return anticipated have the potential to be affected by this deficient practice.	

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F 640	Continued From page 7 Completion" revealed "...Policy Explanation and Compliance Guidelines:... #2...f. Discharge Assesssment- ...completed using the discharge date as the Assessment Reference Date (ARD). Must be completed within 14 days of the discharge date/ARD. " On 10/28/21 at 3:50 PM, an interview with Licensed Practical Nurse (LPN) #3 revealed that Resident #1 was admitted on 5/3/21 and discharged on 5/17/21. LPN #3 confirmed that Resident #1 did not have a Minimum Data Set (MDS) discharge assessment. On 10/28/21 at 3:55 PM, an interview with Licensed Practical Nurse (LPN) #1 revealed that Resident #1 did not have a discharge MDS assessment, and it was an oversight on her part. On 10/28/21 at 4:04 PM, an interview with the Administrator (ADM) confirmed he was responsible for the MDS staff. The ADM stated that the discharge MDS assessment should not have been missed. Record review of Resident #1's Face Sheet revealed Resident #1 was admitted to the facility on 5/3/21 and was discharged on 5/17/21 with return anticipated.	F 640	November 2, 2021, Minimum Data Set nurse staff audited bedhold/discharge reports from April 1, 2021, through October 31, 2021, to ensure all discharge assessments had been completed and transmitted in a timely manner. All assessments are current and in compliance. October 29, 2021, Staff Development Coordinator (Registered Nurse) in-serviced all Minimum Data Set nurse staff on Encoding/Transmitting Resident Assessments which included the requirement and necessity of completing and transmitting all assessments in a timely manner. To ensure that this deficient practice does not reoccur, Minimum Data Set nurse staff will check discharge reports at the end of each month beginning October 2021 and going forward to verify all discharge assessments have been completed. Facility Minimum Data Set 3.0 Completion policy was reviewed on November 10, 2021, by the Quality Assurance and Performance Improvement Committee with no needed changes or revisions made. Minimum Data Set nurse staff will continue weekly audits of assessments beginning November 1, 2021, for four (4) weeks, then monthly for five (5) months. All findings will be reported to the Quality Assurance Performance Improvement Committee monthly beginning November 10, 2021, and continue for the next five (5) months and as needed for any	

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F 640	Continued From page 8	F 640		

recommendations, revisions, and/or resolutions.

November 5, 2021, Minimum Data Set nurse completed and transmitted the missed May 17, 2021, discharge assessment on Resident #1.

All residents discharged with return anticipated have the potential to be affected by this deficient practice.

November 2, 2021, Minimum Data Set nurse staff audited bedhold/discharge reports from April 1, 2021, through October 31, 2021, to ensure all discharge assessments had been completed and transmitted in a timely manner. All assessments are current and in compliance.

October 29, 2021, Staff Development Coordinator (Registered Nurse) in-serviced all Minimum Data Set nurse staff on Encoding/Transmitting Resident Assessments which included the requirement and necessity of completing and transmitting all assessments in a timely manner. To ensure that this deficient practice does not reoccur, Minimum Data Set nurse staff will check discharge reports at the end of each month beginning October 2021 and going forward to verify all discharge assessments have been completed. Facility Minimum Data Set 3.0 Completion policy was reviewed on November 10, 2021, by the Quality Assurance and

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F 640	Continued From page 9	F 640	Performance Improvement Committee with no needed changes or revisions made. Minimum Data Set nurse staff will continue weekly audits of assessments beginning November 1, 2021, for four (4) weeks, then monthly for five (5) months. All findings will be reported to the Quality Assurance Performance Improvement Committee monthly beginning November 10, 2021, and continue for the next five (5) months and as needed for any recommendations, revisions, and/or resolutions.	
F 657 SS=G	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.	F 657		11/18/21

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F 657	Continued From page 10 (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, staff and family interview and facility policy review the facility failed to revise a fall care plan for Resident #111 after multiple falls that occurred for 1 of 5 falls reviewed. Findings include: Record review of the facility policy titled "Care Plan Policy" with revision date 4-2019 revealed "Policy It is the policy of this facility that an individualized, interdisciplinary care plan will be developed and maintained for each resident in the facility. Procedure: It is the responsibility of each nurse to update care plans. When an order is written or an incident occurs, it is the responsibility of the nurse taking the order, or the RN desk nurse documenting the incident to:..#7 Stop and update the care plan immediately... If a resident has a fall or skin tear, you must attempt to have a new intervention for each one since the previous interventions didn't work." Record review of the care plan problem dated 8/23/21 revealed, "FALLS: I am at risk for falls" Record review of the care plan goal dated 8/23/21 revealed, "I will remain free from any major fall-related injuries thru next review."	F 657	Upon return from hospital on November 11,2021, Resident 111□s fall careplan was reviewed by admitting nurse, Minimum Data Set nurse, Director of Nursing, and Assistant Director of Nursing. Appropriate fall interventions have been identified and implemented to reflect resident□s current needs, cognitive status and level of care. Phone careplan conference was held with interdisciplinary team and resident□s responsible party on November 11, 2021. All residents are at risk. One Hundred percent (100%) review of all resident□s fall careplans was initiated on November 1, 2021, by the Director of Nursing, Assistant Director of Nursing, Quality Assurance Nurse, Minimum Data Set/Careplan nurses, and Unit Manager Registered Nurse with a completion date of November 8, 2021. Updates completed if indicated. In-service initiated on October 29, 2021, and completed on November 18, 2021, by Registered Nurse/Administrator from outside facility, for all licensed nurses and interdisciplinary team on Care Plan Timing	

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F 657	Continued From page 11 Record review of the care plan approaches dated 8/23/21 revealed, "Educate resident in safety awareness, Remind resident to call when needing assistance, Keep call light within reach as well as frequently used items, Make sure lighting is appropriate to optimize vision and reduce glare on flooring, Encourage me to wear appropriate foot coverings to prevent slipping/falling, Communication/consult with therapy as needed, Make sure you utilize appropriate lifts at all times, Monitor for fall risk every shift, concave mattress on bed for safety." Record review of the Instant Care Plan dated 8/31/21 revealed "Fall/Trauma-found on floor beside bed" with Interventions that apply to this event noted as; check resident often and neuro checks per protocol. Record review of the Instant Care Plan dated 9/5/21 revealed "Fall/Trauma" with interventions that apply to this event noted as; evaluate for fall precautions, check resident often and neuro checks per protocol. Record review of the Instant Care Plan and dated 9/12/21 revealed "Fall/Trauma-witnessed fall" and injury described as bruise to right (R)hip. Interventions that apply to this event noted as, check resident often. Record review of the Instant Care Plan and dated 9/13/21 revealed "Fall/Trauma-unwitnessed fall, no injuries" with no interventions that apply to this event noted. Record review of the Instant Care Plan dated 9/13/21 revealed "Fall/Trauma-2nd unwitnessed fall, neuro checks within normal limits, complaint	F 657	and Revisions to ensure that careplans of residents with falls are updated after the fall to include additional interventions to attempt to prevent reoccurrence and interventions are resident centered. All new employees will be in-serviced by the Staff Development Nurse while in orientation prior to working with any resident. Fall careplans are to be reviewed during morning clinical meeting Monday through Friday beginning October 29, 2021. Also, beginning October 30, 2021, fall careplans will be reviewed by Registered Nurse/Licensed Practical Nurse supervisor on Saturday and Sunday after a fall to ensure a new intervention is in place. These clinical reviews of Fall Careplans will continue routinely going forward. The facility care plan policy was reviewed on November 10, 2021, by the Quality Assurance and Performance Improvement Committee with revisions made by removing unnecessary language and procedures for better compliance. On October 29, 2021, the Director of Nursing and/or Assistant Director of Nursing initiated plans of monitoring falls and updating of fall careplan after a fall for new and appropriate interventions. Audits of three (3) fall careplans weekly x four (4) weeks beginning October 29, 2021, then two (2) fall careplans weekly x two (2) weeks then three (3) fall careplans monthly x six (6) months. Any concerns will be addressed. All findings will be reported to the Quality Assurance Performance Improvement Committee	

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(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 657	Continued From page 12 of pain to left cheek bone, egg size swelling noted to left back of head with no interventions that apply to this event noted. It revealed that an order was obtained from Medical Director (MD) to send to Emergency Room (ER) for evaluation." Record review of the Instant Care Plan dated 10/3/21 revealed "Fall/Trauma" Injury noted as right hip pain and right hip fracture with note that states, "resident impulsive, fast paced, will not call for assist" Record review of the Instant Care Plan dated 10/26/21 revealed, "Fall/Trauma" with interventions that apply to this event noted as; evaluate for fall precautions, check resident often and neuro checks per protocol. Review of the Face Sheet revealed the facility admitted Resident #111 on 8/23/21 with diagnoses that included; Cerebral Infarction, Hypertension, Type 2 Diabetes mellitus, major depressive disorder, cirrhosis of liver, thrombocytopenia, alcohol abuse, rheumatic multiple valve disease, metabolic encephalopathy, hypothyroidism, Gastro-esophageal reflux disease, chronic pain syndrome hyperlipidemia, difficulty in walking, other abnormalities of gait and mobility, muscle weakness, unspecified lack of coordination, cognitive communication deficit, unspecified dementia without behavior disturbances, anxiety disorder, nontraumatic intracerebral hemorrhage, encounter for attention to gastrostomy, hypomagnesemia, Personal history of traumatic brain injury, anemia, Alzheimer's disease with early onset, dementia with behavioral disturbances, trauma subarachnoid hemorrhage.	F 657	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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F 657	Continued From page 13	F 657		

Record review revealed in Significant Change-Minimum Data Set (MDS) assessment dated 9/30/21 that her BIMS score was 99, indicating that the resident was unable to be assessed.

An interview on 10/28/21 at 9:43 AM with the Registered Nurse (RN) #1 revealed that Instant care plans should have updated interventions, but they feel they have done all they know to do with Resident #111.

An interview on 10/28/21 at 9:55 AM with the Director of Nurses (DON) revealed that after a fall the care plan would need to be updated or an instant care plan used with the date of the fall and any interventions that has been put into place The DON confirmed that anyone with a history of falls should have specific interventions on their care plan. The DON confirmed that Resident 111's care plan update after her falls was an Instant Care Plan and had no specific interventions regarding how often to check the resident. The DON revealed that Resident #111's fall care plan on admission had interventions regarding educating and reminding the resident regarding safety measures. The DON confirmed that based on Resident #111's cognitive ability that her fall care plan interventions regarding educating and reminding were not pertinent for this resident.

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An interview on 10/28/21 at 11:30 AM, with Registered Nurse (RN) #2 revealed the facility has meetings every morning and go over reports, such as falls. She stated that they talk about interventions for the falls. She stated that the QA nurse was responsible for putting new interventions on the care plans. She confirmed

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F 657	Continued From page 14 that Resident #111's care plan had not been updated after her falls with significant in juries.	F 657		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: 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: 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..."	F 689	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 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	11/18/21

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F 689	Continued From page 15 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... 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	F 689	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 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.	

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F 689	Continued From page 16 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." 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	F 689	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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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 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."

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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, 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

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#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 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

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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 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

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F 689	Continued From page 21 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.	F 689		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent	F 812		11/18/21

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F 812	Continued From page 22 facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and facility policy reviews the facility failed to store food to prevent the likelihood of foodborne illness as evidenced by opened items with no open date and unlabeled food items in the refrigerator for one (1) of two (2) kitchen tours. Findings include: Record review of the facility policy titled Food Storage Policy with a revised date of 4/23/19 under Food Storage Policy: " Sufficient storage facilities will be provided to keep foods safe, wholesome, and appetizing. Food will be stored in an area that is clean, dry, and free from contaminates. Food will be stored, at appropriate temperatures and by methods designed to prevent contamination or cross contamination... Procedure:...13. leftover food will be stored in covered or wrapped carefully and securely. Each item will be clearly labeled and dated before being refrigerated. Leftover food is used within 7 days or discarded as per the 2013 Federal Food Code... Check state regulations as state regulations as state regulations may allow shorter time frames for use of leftovers." On 10/25/21 at 1:40 PM, during the initial kitchen	F 812	October 25, 2021, all foods from breakfast were labeled and dated. All other items from refrigerator were immediately discarded. All residents have the potential to be affected by this deficient practice. October 25, 2021, audit of refrigerators on each unit was performed by the Dietary Manager to ensure that all food was properly covered, labeled and dated. No other items were found to be not dated. October 29, 2021, Registered Dietician (consultant) in-serviced all dietary staff on Food Procurement, Store/Prepare/Serve Sanitary which included labeling and dating all foods/drinks after opening and storing in refrigerators. All new employees will be in-serviced by the Staff Development Coordinator (Registered Nurse) and trained by dietary staff while in orientation before being allowed to work independently. Facility Food Storage policy was reviewed on November 10, 2021, by the Quality Assurance and Performance Improvement Committee with no needed changes or revisions	

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F 812	Continued From page 23 tour the State Agency (SA) observed in the four (4) door refrigerator a white container with of pimento and cheese spread with approximately a cup leftover in the bottom with no open date, a white container of chicken salad approximately three fourths full with no open date, a white container with tuna salad approximately half full with no open date, a white container with cucumber salad and onion approximately half full with no open date, a bowl with a lid that was dated 9/29/21 and chili written beside the date, and a glass of a tan colored milk like liquid covered with plastic wrap, with two (2) spots of a dark substance floating on top of the liquid. This glass was not labeled with the contents or a date. An interview on 10/25/21 at 1:55 PM, with the Dietary Supervisor revealed that all opened items placed in the refrigerator should be covered and dated with the open date. She revealed that they do not have a specific schedule for checking opened items for dates and that everyone knows that they should be dated. In the presence of the SA, the dietary supervisor removed each item from the four (4) door refrigerator and she confirmed that the pimento and cheese, the chicken salad, the tuna salad, and the cucumber and onion salad were opened and not dated and she confirmed that the bowl with the lid had a date of 9/29/21 and chili written by the date and that the milk like liquid was honey thickened milk and that there were 2 dark spots that looked like mold to her and it was not dated. She confirmed that opened items without dates could cause the food to spoil and cause a foodborne illness. An interview on 10/25/21 at 2:05 PM, with the Dietary Manager revealed that all opened items should be dated when placed in the refrigerator	F 812	made. Food Service Supervisor, Dietary Manager, and/or Registered Dietician will complete an audit of all refrigerators weekly for four (4) weeks beginning November 5, 2021, then monthly for five (5) months. Dietary Manager will report findings to the Quality Assurance Performance Improvement Committee monthly beginning November 10, 2021, and continue for the next five (5) months and as needed for any recommendations, revisions, and/or resolutions.	

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 _____	10/28/2021

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 812	Continued From page 24 and that food not dated could definitely cause issues and cause a foodborne illness. She revealed that the head cook and assistant cook are responsible to check the refrigerators daily for opened items to ensure that they are dated and she confirmed that they do not have a log for this. She revealed that this is in their job description to check the refrigerators and that they know to do this. She revealed that she spot checks the refrigerators herself and that she checked them about 2 weeks ago but she guessed that she had overlooked the bowl of chili dated 9/29/21. She revealed that the last in-service for food storage which included labeling and dating of food items was on 4/28/21 that was given by the Registered Dietician (RD). Record review of the in-service dated 4/28/21 conducted by the RD revealed that all items should be covered, labeled and dated. Leftovers thrown out after 72 hours. An interview on 10/28/21 at 8:50 AM, with the Administrator revealed that if opened food items are placed in the refrigerator without being dated that they could spoil and cause someone to get sick.	F 812		
F 868 SS=D	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the	F 868		11/18/21

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F 868	Continued From page 25 administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record reviews and facility policy review the facility failed to maintain the appropriate staff at the quarterly Quality Assurance (QA) meetings for two(2) of four(4) quarterly meetings reviewed. Findings include: Review of the facility policy titled, "Quality Assurance/Assessment and Performance Improvement Plan," dated 01/29/20, stated, "The QA committee consists of the Director of Nursing/Designee (DON), the Medical Director, Administrator, Dietary Manager, Social Services, Quality Assurance Nurse, plus 2 (two) non-licensed staff." Record review of the QA sign in sheets revealed on 10/28/21 at 11:30AM, the QA sign-in sheets were dated from October 2020 through July 2021. October 2020 QA sign in sheet stated, "No QAPI meeting held." The January 27, 2021 QA sign in sheet did not have the Medical Director in attendance and stated, "Elected to not attend meeting." The July 28, 2021 sign-in sheet revealed that the Medical Director was not in attendance for the QA meeting.	F 868	November 10, 2021, the Quality Assurance Director held the fourth quarter Quality Assurance committee meeting. Signatures of all attendees were obtained on the sign-in sheet. The Medical Director, Director of Nursing and the Administrator all attended along with several other staff members. All residents have the potential to be affected by this deficient practice. October 29, 2021, Staff Development Coordinator (Registered Nurse) in-serviced the Administrator, Director of Nursing, Quality Assurance Director on the requirement for 1. the Quality Assurance committee to meet at least quarterly and/or as-needed and 2. for it to include the Director of Nursing/designee, Medical Director/designee, and three other staff members with one being the Administrator, owner, board member or other individual in a leadership role. The Administrator will audit the Quality Assurance and Performance Improvement sign-in sheets quarterly for compliance beginning November 2021	

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F 868	Continued From page 26 Interview on 10/28/21 at 1:45PM, with the Director of Nurses (DON) confirmed that the facility did not have a QA meeting in September and have not had a QA meeting so far for the month of October. The DON confirmed that after she reviewed the monthly QA meeting sign-in sheets that the facility either did not have the appropriate staff at the meetings or either they missed the monthly meeting and the facility did not have the required quarterly meetings with the required staff present at the meetings and that the facility was not in compliance with federal requirements. Interview with the current QA nurse on 10/28/21 at 2:25PM, stated, "I began this job about the second week of October. We are going to get with the Medical Director and plan a meeting for November. The Medical Director is here in the building a lot. He wouldn't have a problem attending."	F 868	and will routinely continue going forward. Facility Quality Assurance policy was reviewed on November 10, 2021, by the Quality Assurance and Performance Improvement Committee with no needed changes or revisions made. Beginning November 2021, the Assistant Director of Nursing will audit the Quality Assurance and Performance Improvement sign-in sheets monthly for six (6) months to ensure the committee is meeting as-needed and quarterly at a minimum, and that signatures are obtained from all attendees. All findings will be reported to the Quality Assurance Performance Improvement Committee monthly beginning November 10, 2021, and continue for the next five (5) months and as needed for any recommendations, revisions, and/or resolutions.	