

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255257	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/09/2024
NAME OF PROVIDER OR SUPPLIER The Windsor Place		STREET ADDRESS, CITY, STATE, ZIP CODE 81 Windsor Boulevard Columbus, MS 39702	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>47874</p> <p>Based on observation and staff interview, the facility failed to ensure a resident had a wheelchair in good repair for one (1) of 86 residents requiring a wheelchair for mobility. Resident #51</p> <p>Findings include:</p> <p>The facility provided a statement on letter head that read, The Proper Name of facility does not, currently, have a formal written policy regarding resident equipment being in good condition. Any issues of resident equipment not being in good condition or malfunctioning are to be reported to maintenance upon discovery.</p> <p>An observation on 10/7/24 at 12:05 PM, revealed Resident #51 sitting in his wheelchair with arm rests on the wheelchair that were torn and tattered with sharp plastic edges and the yellow foam visible.</p> <p>An observation on 10/8/24 at 11:01 AM, revealed Resident #51 lying in bed. His wheelchair was in the room, with the arm rest in disrepair. The right arm rest had the yellow foam torn away, and the black hard plastic was exposed, which had jagged edges. The left arm rest had the black vinyl torn, and the yellow foam was exposed.</p> <p>An interview with Licensed Practical Nurse (LPN) #1 on 10/8/24 at 11:04 AM, confirmed Resident #51's arm rest needed to be repaired and revealed the resident could scratch the skin on his arms. She revealed the resident's equipment should be in good repair and explained that staff must let maintenance know by telling him or doing a work order for issues to be addressed.</p> <p>An interview with Maintenance #2 on 10/8/24 at 11:14 AM, revealed he would be responsible for any maintenance on the wheelchairs. He revealed the staff fill out a work order for anything that needs repairing. He revealed he had not received a work order for Resident #51's wheelchair and explained he was not aware it was in bad condition.</p> <p>Record review of the Admission Record revealed the facility admitted Resident #51 on 1/17/18 with a medical diagnosis of Hemiplegia and Hemiparesis following cerebral infarction affecting the left non-dominant side.</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255257	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/09/2024
NAME OF PROVIDER OR SUPPLIER The Windsor Place		STREET ADDRESS, CITY, STATE, ZIP CODE 81 Windsor Boulevard Columbus, MS 39702	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0655</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>47157</p> <p>Based on staff interview, record review and facility policy review, the facility failed to develop a baseline care plan related to skin integrity concerns for a resident with excoriation to the buttocks. The resident developed a pressure ulcer within four days of admission to the facility. This was for one (1) of 28 care plans reviewed. Resident #39.</p> <p>Cross reference: F686</p> <p>Findings include:</p> <p>A review of the facility policy titled, Care Plan Policy, revealed, on admission a care plan must be completed.</p> <p>A review of the Baseline Care Plan dated 8/23/24 for Resident #39 revealed Skin risk: current skin integrity issues checked. Specific skin integrity issue: Excoriation to buttock Physician orders: see Medication Administration Record (MAR) and Treatment Administration Record (TAR).</p> <p>A record review of the Wound Assessment Report dated 8/23/24, the day of admission, revealed Resident #39 was assessed to have excoriation to the buttocks area, with a new treatment order for Calmoseptine for excoriation to the buttocks.</p> <p>On 10/8/24 at 2:05 PM, in a record review of the Order Summary Report for Resident #39 and interview with the Infection Control Nurse stated she was unable to find where the physician's order for the treatment of the excoriation to the buttocks was entered into the computer system on 8/23/24.</p> <p>On 10/8/24 at 2:10 PM, during a record review of the August 2024 TAR for Resident #39 and an interview with the Infection Control Nurse on she revealed she was unable to find where a treatment was initiated on 8/23/24 for the excoriation to the buttocks and she confirmed that the resident now has a Stage 2 pressure ulcer to the buttocks.</p> <p>An interview with the Minimum Data Set (MDS) Coordinator on 10/09/24 at 8:23 AM, she revealed that they failed to develop the baseline care plan for Resident #39 and failed to implement the new skin orders on the day of her admission for the excoriation to the buttocks. She revealed the purpose of the baseline care plan is to give staff a guide to the care the residents requires until the comprehensive care plan can be developed.</p> <p>Review of the Admission Record revealed the facility admitted Resident # 39 on 8/23/24 with a diagnosis of Encounter for orthopedic aftercare following surgical amputation.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255257	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/09/2024
NAME OF PROVIDER OR SUPPLIER The Windsor Place		STREET ADDRESS, CITY, STATE, ZIP CODE 81 Windsor Boulevard Columbus, MS 39702	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>41878</p> <p>Based on observation, resident and staff interview, record review, and facility policy review, the facility failed to implement a care plan for shaving a dependent resident for one (1) of 25 resident care plans reviewed. Resident #80</p> <p>Findings include:</p> <p>Record review of facility policy titled, Care Plan Policy dated 11/21, revealed, It is the policy of this facility that an individualized, interdisciplinary care plan will be developed and maintained for each resident in the facility. If the resident has a working care plan, you may use this and update it as indicated.</p> <p>Record review of Resident #80's Care Plan date initiated 9/4/24 revealed, the resident has an ADL, self-care performance deficit related to congestive heart failure and diabetes mellitus which includes an intervention for bathing/showering.</p> <p>On 10/07/24 at 12:30 PM, during an observation and interview Resident #80 stated he wanted to be shaved and felt that the staff would do this today since it was shower day. He stated he was unsure when he was last shaved and told his family that if they would bring him a razor, he would shave himself. Observation revealed the resident had an approximate one-third inch long, scruffy stubble of facial hair on bearded areas of his cheeks, chin, and upper lip.</p> <p>On 10/8/24 at 8:40 AM, an observation and interview revealed Resident #80 was still unshaved. He stated he preferred to be clean shaven and was not used to being unshaven.</p> <p>On 10/8/24 at 2:30 PM Resident #80 was observed and interviewed in the hallway propelling himself in the wheelchair and was still unshaved. He stated the staff had not shaved him and he wanted this to be done.</p> <p>During an interview on 10/8/24 at 2:40 PM, the Director of Nursing (DON) stated the resident was scheduled for bathing and showering on Monday, Wednesday, and Friday, and he did not typically refuse care, but the care record from yesterday revealed the resident refused his shower. She stated each resident has the right to refuse care, but the process to ensure care is done as desired included any refusal of care to be reported to the nurse and the nurse should followed up with the resident for options for care and document that in the resident's notes and that was not done. She also stated the staff are to follow up with the resident at a later time to see if care is wanted at that time and there was no documentation that was done. The DON acknowledged that grooming and shaving was part of the bathing activities of daily living (ADL) care. She confirmed the facility failed to shave the facial hair of a resident that preferred to be clean shaven. She confirmed the care plan was to give staff information on the care needed and preferences of each resident and the ADL care plan was developed but it was not followed since shaving and grooming was a part of the bathing care plan.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255257	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/09/2024
NAME OF PROVIDER OR SUPPLIER The Windsor Place		STREET ADDRESS, CITY, STATE, ZIP CODE 81 Windsor Boulevard Columbus, MS 39702	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview with the Minimum Data Set (MDS) Coordinator on 10/9/24 at 9:15 AM revealed she was the person responsible for the development of care plans and stated the care plan should be followed by the staff since it guides the staff in the care and preferences of each resident. She stated this resident had a care plan developed for ADL bathing care which included grooming/shaving, but confirmed this was not followed.</p> <p>Record review of Resident #80's Admission Record revealed the facility admitted the resident on 6/22/22. Diagnoses included Type 2 Diabetes Mellitus and Osteoarthritis.</p> <p>Record review of Resident #80's quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 8/28/24, revealed a Brief Interview for Mental Status (BIMS) score of 10 which indicated the resident had moderate cognitive impairment.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255257	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/09/2024
NAME OF PROVIDER OR SUPPLIER The Windsor Place		STREET ADDRESS, CITY, STATE, ZIP CODE 81 Windsor Boulevard Columbus, MS 39702	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>41878</p> <p>Based on observation, resident and staff interview, record review, and facility policy review, the facility failed to shave a resident that was dependent on staff for care for one (1) of three (3) residents reviewed for Activities of Daily Living (ADL). Resident #80</p> <p>Findings include:</p> <p>Record review of facility policy titled, Activities of Daily Living Policy, undated, revealed, It is the policy of the facility to encourage resident choice and participation in activities of daily living (ADL) and provide oversight cuing and assistance as necessary. ADL's included bathing, dressing, grooming, hygiene, toileting, and eating. CNA (Certified Nursing Assistant) will review the resident care card for information on individual care needs and preferences. CNA will provide needed oversight, cuing or assistance to resident. CNA will report any changes in ability or refusals to the nurse.</p> <p>During an observation and interview on 10/07/24 at 12:30 PM, Resident #80 stated he wanted to be shaved and felt that the staff would do this today since it was shower day. He stated he was unsure when he was last shaved and he told his family that if they would bring him a razor, he would shave himself. Observation revealed the resident had an approximate one-third inch scruffy stubble of facial hair on bearded areas of his cheeks, chin, and upper lip.</p> <p>An observation and interview on 10/8/24 at 8:40 AM, revealed Resident #80 was still unshaved and stated he preferred to be clean shaven and was not used to being unshaven.</p> <p>Resident #80 was observed on 10/8/24 at 2:30 PM and was still unshaved. He stated the staff had not shaved him and he wanted this to be done. The Director of Nursing (DON) came to the resident and Resident #80 informed her that he wanted to be shaved and had asked staff for this, but it had not been done. The DON informed him that it was the responsibility of the Certified Nursing Assistants (CNAs) to shave him and she assured him she would get this done for him. The DON acknowledged that grooming and shaving was part of the bathing activity of daily living (ADL) care and confirmed the facility failed to shave the facial hair of a resident that preferred to be clean shaven.</p> <p>Record review of an ADL care summary revealed Resident #80 was scheduled for baths on Monday, Wednesday, and Friday.</p> <p>Record review of Resident #80's Admission Record revealed the facility admitted the resident on 6/22/22. Diagnoses included Type 2 Diabetes Mellitus and Osteoarthritis.</p> <p>Record review of Resident #80's quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 8/28/24, revealed a Brief Interview for Mental Status (BIMS) score of 10 which indicated the resident had moderate cognitive impairment.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255257	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/09/2024
NAME OF PROVIDER OR SUPPLIER The Windsor Place		STREET ADDRESS, CITY, STATE, ZIP CODE 81 Windsor Boulevard Columbus, MS 39702	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>47157</p> <p>Based on observation, resident and staff interview, record review and facility policy review, the facility failed to provide necessary treatment and services to promote healing and prevent new ulcers from developing for (1) one of five (5) residents with wounds reviewed. Resident #39</p> <p>Findings include:</p> <p>A review of the facility policy titled, Overview of Skin and Wound Care Management, revealed, the facility staff strives to prevent/patient skin impairment. The Interdisciplinary team works with the resident and family to identify and implement interventions to prevent and treat potential skin integrity issues. Components of the skin care and wound management program include, but are not limited to, the following: 2.) Implementation of prevention strategies to minimize the potential for developing pressure ulcers and skin integrity issues.</p> <p>An interview with Resident # 39 on 10/07/24 at 11:24 AM, revealed she had a pressure sore on her lower buttocks that she got while in the facility.</p> <p>A record review of the Wound Assessment Report dated 8/23/24 revealed Resident #39 was assessed to have excoriation to the buttocks area with a new treatment order for Calmoseptine treatment to the buttocks.</p> <p>A record review of the Order Summary Report for Resident #39 and interview with the Infection Control Nurse on 10/8/24 at 2:05 PM, she stated she was unable to find the physician's order for the Calmoseptine treatment to the excoriation on the buttocks was even entered into the computer system on 8/23/24 and confirmed that the facility failed to implement the physician's order.</p> <p>A record review of the August 2024 Treatment Administration Record (TAR) for Resident #39 and interview with the Infection Control Nurse on 10/8/24 at 2:10 PM she revealed she was unable to find where a treatment was initiated on 8/23/24 for the excoriation to the buttocks and confirmed that not performing the treatment as ordered may have contributed to the acquired pressure ulcer.</p> <p>Record review of the Wound Assessment Report dated 8/27/24 for Resident #39 completed by Registered Nurse (RN) #1 revealed a new stage (2) two pressure ulcer to the right buttock measuring 1 centimeter (CM) in length, 1.5 CM in width, and 0.1 CM in depth.</p> <p>Review of the Order Summary Report for Resident # 39 revealed an order dated 8/27/24 Cleanse stage 2 to the right buttock with (NS) normal saline, pat dry, apply collagen, and cover with dry dressing every day (QD) and as needed (PRN). Monitor dressing to the right buttock for soilage/dislodgement as needed.</p> <p>Review of the August 2024 TAR for Resident # 39 revealed cleanse stage 2 to the right buttock with NS, pat dry, apply collagen, and cover with dry dressing QD and PRN. Monitor dressing to the right buttock for soilage/dislodgement as needed dated 8/27/24.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255257	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/09/2024
NAME OF PROVIDER OR SUPPLIER The Windsor Place		STREET ADDRESS, CITY, STATE, ZIP CODE 81 Windsor Boulevard Columbus, MS 39702	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>An interview with Registered Nurse (RN) #1 on 10/8/24 at 3:15 PM, he revealed on 8/27/24 Resident #39 was assessed to have a stage 2 pressure ulcer to the right buttock/ischial area. He revealed that he and the treatment nurse obtained an order for Collagen treatment from the provider and treated the wound.</p> <p>An interview with the Director of Nursing (DON) on 10/08/24 at 3:30 PM, she revealed after reviewing the August 2024 TAR for Resident #39 she was unable to find where the treatment for the excoriation to the buttocks was ever started.</p> <p>An interview with the Assistant Director of Nursing (ADON) on 10/09/24 8:45 at AM she revealed the physician's order for the Calmoseptine treatment on 8/23/24 for Resident #39 was accidentally missed and it could have contributed to the deterioration of the area to the buttocks.</p> <p>Review of the Admission Record revealed the facility admitted Resident # 39 on 8/23/24 with a diagnosis of Encounter for orthopedic aftercare following surgical amputation.</p> <p>Record review of Resident # 39's Section C of the Admission Minimum Data Set (MDS) revealed on 8/29/24 a Brief Interview for Mental Status (BIMS) score was 15, indicating the resident was cognitively intact.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255257	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/09/2024
NAME OF PROVIDER OR SUPPLIER The Windsor Place		STREET ADDRESS, CITY, STATE, ZIP CODE 81 Windsor Boulevard Columbus, MS 39702	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>47157</p> <p>Based on observation, resident and staff interview, and record review the facility failed to ensure the residents had a environment free of potential hazards as evidenced by cleaning chemicals not being securely locked in a janitors storage closet for two (2) of five (5) units in the building. 400 Hall and Dementia Unit.</p> <p>Findings include:</p> <p>Review of a document provided by the facility, on facility letterhead revealed the facility does not currently have a formal written policy specific to resident accident prevention or monitoring.</p> <p>An observation on 10/7/24 at 11:20 AM on the Dementia Unit revealed a door with a sign that read Janitor's Closet was unlocked and held three full bottles of disinfectant.</p> <p>An interview and observation on 10/7/24 at 11:25 AM with Certified Nurse Assistant (CNA) #1 confirmed the Janitors Closet has a coded lock that was broke and the room was unlocked. She confirmed there were three full bottles of liquid disinfectant in the closet. She stated that she had not told maintenance and is not sure if they know. She revealed that the closet with the cleaning supplies should always be locked. This observation revealed this unit was an open unit with all resident rooms, day room and janitors closet within view from all areas and the nurses station is directly across from the janitors closet. She confirmed that the janitors closet could always be seen by the staff because it is a small open unit with three (3) CNA's and one nurse in the unit at all times.</p> <p>An observation on 10/7/24 at 11:45 AM of the 400-hall revealed there was a door labeled Janitors Closet that had a coded lock that was not locked with four bottles of liquid disinfectant.</p> <p>An interview and observation on 10/7/24 at 11:50 AM with Licensed Practical Nurse (LPN) #1 confirmed that the Janitors Closet on the 400 hall was unlocked but should always be locked, because there were chemicals that they would not want the residents to have access to. This observation revealed the janitors closet was directly across from the nurses station and was in view from the 300 and 400 hall. She confirmed that there was a staff member that sat at the nurses desk at all times, answering phone calls and call lights and also the dining area was open and within view of the closet.</p> <p>An interview on 10/7/24 at 11:55 AM with Housekeeping #1 confirmed that the Janitors Closet on the 400 hall had a coded lock that had been broken for a few days, but she is not sure if maintenance knows about it.</p> <p>An interview on 10/8/24 at 9:15 AM with Maintenance #2 confirmed that the locks on the Janitors Closets on the 400 hall and the Dementia Unit were both broken. He stated he put batteries in the lock on the 400-hall last week and thought it was fixed, but he had not been told about the one on the Dementia Unit.</p> <p>An interview on 10/8/24 at 9:30 AM with the Administrator confirmed the Janitors Closets should always be locked.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255257	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/09/2024
NAME OF PROVIDER OR SUPPLIER The Windsor Place		STREET ADDRESS, CITY, STATE, ZIP CODE 81 Windsor Boulevard Columbus, MS 39702	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47874</p> <p>Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure an informed consent was obtained for the application of bed rails for one (1) of 25 sampled residents. Resident #30</p> <p>Findings Include:</p> <p>Review of the facility policy titled Side Rails Policy with a revision date of 10/19 revealed under, Policy: it is the policy of this facility to keep residents as safe as possible while they are in the bed, as well as enable them to be as active in their care physically as they are able.</p> <p>An observation of Resident #30 on 10/7/24 at 4:05 PM revealed he was lying in bed. The left side of the bed was against the wall, and one-half (1/2) side rails were raised on both sides of the bed.</p> <p>Record review of the Physician's Orders for Resident #30 revealed an order dated, 10/27/20, 1/2 (one half) siderails up x (times) 2 (two) when in bed for increased bed mobility & (and) independence.</p> <p>An interview with the Minimum Data Set (MDS) Nurse on 10/9/24 at 8:20 AM revealed bed rail assessments were completed on admission and quarterly. She revealed the benefits, and the risk of the bed rails were explained to the family and a consent was signed as part of the admission paperwork.</p> <p>Record review of the Bed Rail assessment dated [DATE] for Resident #30 revealed, Bilateral Side Rails/Assist Bar are indicated and serve as an enabler to promote independence.</p> <p>Record review of the Resident Dashboard revealed, Resident #30 required one-person extensive assist with bed mobility.</p> <p>An interview with the Assistant Director of Nursing (ADON) on 10/9/24 at 10:20 AM, confirmed a consent was not signed for bed rails for Resident #30 and revealed this should have been done before applying the bed rails to ensure the family was notified of the risk.</p> <p>Record review of the Resident Dashboard revealed the facility admitted Resident #30 on 10/26/20 with a medical diagnosis of Hemiplegia following cerebral infarction affecting the left non-dominant side.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255257	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/09/2024
NAME OF PROVIDER OR SUPPLIER The Windsor Place		STREET ADDRESS, CITY, STATE, ZIP CODE 81 Windsor Boulevard Columbus, MS 39702	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>31934</p> <p>Based on observation, interview, record review, and facility policy review, the facility failed to maintain an account of all controlled medications and provide evidence of periodic reconciliation for two (2) of five (5) medication carts reviewed during medication pass. 100 hall and 200 hall.</p> <p>Findings include:</p> <p>Record Review of the facility policy titled, Pharmacy Delivery, Revised 9/4/15, revealed the policy read, The dispensing pharmacy will transport medication to the facility in a manner that prevents contamination, degradation, and diversion of medications.</p> <p>Review of Resident #80's Physician orders dated 08/01/2024 revealed Hydrocodone/APAP(acetaminophen) 10-325 MG(milligrams), Give 1/2 TABLET by mouth every 4 hours as needed for pain. The label on the medication card was not changed to reflect the new order.</p> <p>Observation of Resident #80's Controlled Substance Record during medication pass on 10/09/24 at 8:10 AM revealed instructions for Hydrocodone/APAP 10-325 MG, Give 1 TABLET by mouth every 4 hours as needed for pain. On 09/25/2024, 09/26/2024, 09/28/2024, 09/29/2024, and 10/07/2024 the record revealed (1) tablet signed out by Licensed Practical Nurse (LPN) #7 but 1/2 tablet was not recorded as wasted or witnessed.</p> <p>Review of the medication card for Resident #80's Hydrocodone/APAP 10-325 MG, revealed dose #41 was missing from the card and was not accounted for on the Controlled Substance Record.</p> <p>Interview on 10/09/2024 at 8:10 AM with LPN #4 on 100 Hall revealed LPN #4 confirmed 09/25/2024, 09/26/2024, 09/28/2024, 09/29/2024, and 10/07/2024 (1) tablet signed out by LPN #7 but 1/2 tablet was not recorded as wasted for Resident #80. LPN #4 also confirmed a missing tablet and stated the card was received from the pharmacy with dose #41 missing.</p> <p>Review of the pharmacy delivery Packing Receipt dated 5/4/24 revealed LPN #6 and LPN #4 signed as receiving the 60 Hydrocodone/APAP 10-325 MG pills medication card with no notation of a missing dose.</p> <p>Review of the Controlled Substance Record narcotic count record revealed 60 Hydrocodone/APAP 10-325 MG pills received by LPN #6 with no notation of pill missing for dose #41.</p> <p>Review of the shift count signature records revealed no notations of a missing dose or waste of Hydrocodone/APAP 10-325 MG dose #41.</p> <p>Record review of the facility's narcotic sheets Controlled Substance Record revealed no Received By (Sign): Date nurse signature or date received for 18 Controlled Substance Records.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255257	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/09/2024
NAME OF PROVIDER OR SUPPLIER The Windsor Place		STREET ADDRESS, CITY, STATE, ZIP CODE 81 Windsor Boulevard Columbus, MS 39702	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 10/09/24 at 9:15 AM, the facility's Consultant Pharmacist stated he performs random audits of the narcotic sign in sheets and narcotic counts but has not noted any issues during the audits. The facility's Consultant Pharmacist stated he did not have evidence of audits, but the facility keeps a record of medication deliveries.</p> <p>Interview by phone on 10/09/24 at 11:45 AM with the Pharmacy Technician from (proper name of pharmacy) revealed that the pharmacy delivers resident medications as needed and facility keeps the original receipt sheet then faxes a copy signed by a facility nurse back to the pharmacy.</p> <p>Interview on 10/09/24 at 12:50 PM with the Director of Nurses (DON) and Assistant Director of Nurses (ADON) revealed the facility keeps the pharmacy medication delivery receipts in the business office. DON stated that discontinued narcotics are removed from the carts and placed in a locked box in the medication room which is also locked. She stated that when the pharmacist makes monthly rounds, the DON and Pharmacist remove the narcotics and destroy the medications with a liquid designed for this purpose and then disposed. DON provided the logbook with evidence of destruction with signatures of Pharmacist and DON noted.</p> <p>An interview on 10/09/24 at 1:50 PM with the Business Office Representative confirmed the pharmacy medication delivery receipts were kept by the business office.</p> <p>Record review of the pharmacy medication delivery receipts Packing Slip revealed receiving nurse's signature on each delivery form.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255257	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/09/2024
NAME OF PROVIDER OR SUPPLIER The Windsor Place		STREET ADDRESS, CITY, STATE, ZIP CODE 81 Windsor Boulevard Columbus, MS 39702	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>31934</p> <p>Based on interview, record review, and facility policy review, the facility failed</p> <p>1) to ensure a medication order, medication administration record, and narcotic record label were all labeled correctly for one (1) of five (5) medication carts reviewed during medication pass, (100 hall medication cart) and;</p> <p>2) the facility failed to securely store medications when two medication capsules were found sitting in a clear medication cup in a resident's room for 1 of 124 residents observed on initial tour. (Resident #28).</p> <p>Findings include:</p> <p>100 Hall Medication Cart</p> <p>Review of the facility policy, Narcotic Medication Accountability updated 1/02, revealed 3. As narcotic medication is used/wasted, the nurse responsible should document the usage and any wastage on the accountability record.</p> <p>Observation of Resident #80's Controlled Substance Record revealed instructions for Hydrocodone/APAP(acetaminophen) 10-325 MG (milligrams), Give 1 TABLET by mouth every 4 (four) hours as needed for pain.</p> <p>Review of Resident #80's Physician orders dated 08/01/2024 revealed Hydrocodone/APAP 10-325 MG, Give 1/2 TABLET by mouth every 4 hours as needed for pain. The label on the medication card was not changed to reflect the new order.</p> <p>Interview on 10/09/2024 at 8:10 AM with Licensed Practical Nurse (LPN) #4 on 100 Hall revealed LPN #4 confirmed 09/25/2024, 09/26/2024, 09/28/2024, 09/29/2024, and 10/07/2024 (1) tablet signed out by LPN #7 but 1/2 tablet was not recorded as wasted for Resident #80. LPN #4 also confirmed a missing tablet and stated the card was received from the pharmacy with dose #41 missing.</p> <p>Resident #28</p> <p>During the initial tour rounds on 10/07/24 at 11:00 AM, an observation of Resident # 28's room from the hallway doorway revealed a clear medication cup with what appeared to medication in the cup sitting next to the television. Upon entrance to the room, the clear medication cup sitting next to the television on the dresser contained two bright yellow and white capsules.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255257	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/09/2024
NAME OF PROVIDER OR SUPPLIER The Windsor Place		STREET ADDRESS, CITY, STATE, ZIP CODE 81 Windsor Boulevard Columbus, MS 39702	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An observation of the two yellow and white capsules in Resident # 28 room with Registered Nurse (RN) # 1 on 10/07/24 at 11:05 AM, he confirmed the capsules were on the dresser and should not be in the room and removed the capsules from the room. In a continued observation with RN #1 of Resident#28's medications, he revealed the yellow and white capsules that were found in Resident #28's room were identified as Gabapentin 300 milligrams (mg) and confirmed Resident #28 receives one 300 mg tablet every night at bedtime. He also confirmed the resident did not have an order to self-administer medications and revealed that staff should always ensure each resident has taken their medications before leaving the resident. RN #1 then stated concerns about medications being left in the room is that the resident could have taken the extra pills and had a reaction.</p> <p>Review of the Active Orders for Resident #28 revealed and order for Gabapentin 300 mg capsule give one capsule by mouth at bedtime.</p> <p>In an interview with Resident # 28 on 10/07/24 at 11:10 AM, he revealed that the pills in his room were for his bowels and stated the nurse last night left him an extra pill, and he was saving them until he needed them. He then stated, I will take them both when I get back to the room.</p> <p>In an interview with LPN # 3 on 10/07/24 at 11:22, she confirmed that Resident #28 cannot self-administer medications and revealed that staff should always watch residents take their medications. She then revealed that with the medications being left in the room, it placed residents at risk for accidentally ingesting the medications, causing possible adverse reactions.</p> <p>In an interview with the Director of Nursing (DON) on 10/08/24 at 11:38 AM, she revealed no medications should ever be left in a resident's room. She stated the resident could have accidentally ingested extra doses, or a wandering resident could have gotten the medication. The DON stated she spoke with Resident #28 on 10/7/24 and stated he was saving the medication to give it back to the nurse, and he stated he paid for it and was not going to waste it. The DON revealed in her professional opinion that the nursing staff could not have observed Resident #28 take his medications because if they did, he would not have been able to save the medications that were found in his room.</p> <p>Review of the Admission Record revealed the facility admitted Resident # 28 on 8/20/24 with a diagnosis of Unspecified Dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and Anxiety.</p> <p>Record review of Resident # 28's Section C of the Admission Minimum Data Set (MDS) revealed on 8/26/24 a Brief Interview for Mental Status (BIMS) score was 11, indicating the resident was moderately cognitively impaired.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255257	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/09/2024
NAME OF PROVIDER OR SUPPLIER The Windsor Place		STREET ADDRESS, CITY, STATE, ZIP CODE 81 Windsor Boulevard Columbus, MS 39702	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>47874</p> <p>Based on observation, staff interview, and facility policy review, the facility failed to label and date open items in the pantry, refrigerator, and freezer for one (1) of two (2) kitchen tours during the survey.</p> <p>Findings Include:</p> <p>Review of the facility policy titled Food Storage undated, revealed under, Policy . Foods will be stored, at appropriate temperatures and by methods designed to prevent contamination or cross contamination . 14. Refrigerated food storage . f. All foods should be covered, labeled and dated. Also revealed under, 15. Frozen Foods: c. All foods should be covered, labeled and dated. All foods will be checked to assure that foods will be consumed by their safe use by dates or discarded.</p> <p>During initial tour of the kitchen on 10/7/24 at 11:20 AM, with the Dietary Manager (DM) #1, an observation of the walk-in refrigerator revealed, a 5-pound (lb.) clear bag of shredded mozzarella cheese that had been opened and had one-fourth (1/4) of the bag remaining, which was unlabeled and undated. Also revealed a 5 lb. container of low-fat cottage cheese that was opened and was undated. An observation of the walk-in pantry revealed a 32-ounce (oz) box of chicken broth, which was open and undated. DM #1 confirmed the box read refrigerate after opening and revealed it was not stored properly after opening and must be trashed. An observation of the walk-in freezer revealed a blue bag of six meat-like patties, which the DM confirmed were pork fritters and had not been labeled and dated after opening. Also revealed a blue bag that contained a round breaded food that the DM #1 confirmed was breaded squash and was opened and was also not labeled and dated.</p> <p>An interview with the Dietary Manager #1 on 10/7/24 at 11:55 AM, revealed the kitchen staff had been educated on making sure foods were labeled and dated when they were opened to ensure they use the oldest foods first. She confirmed, if the food was not dated when opened or stored appropriately, it could make someone sick.</p> <p>An interview with the Administrator (ADM) on 10/9/24 at 9:34 AM revealed his expectations were for the kitchen staff to label and date things that were opened and to ensure the foods were not out of date and stored appropriately. He confirmed this should be done so it did not make anybody sick.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255257	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/09/2024
NAME OF PROVIDER OR SUPPLIER The Windsor Place		STREET ADDRESS, CITY, STATE, ZIP CODE 81 Windsor Boulevard Columbus, MS 39702	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>31934</p> <p>Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure Enhanced Barrier Precautions (EBP) were initiated for one (1) of five (5) residents reviewed for EBP. Resident #370</p> <p>Findings include:</p> <p>Review of the facility's Enhanced Barrier Precautions Policy, dated 04/2024, revealed, Purpose: Enhanced Barrier Precautions (EBP) refer to infection control interventions designed to reduce transmission of multidrug-resistant organisms (MDRO) by wearing gown and gloves during high contact resident care activities. The use of EBP does not restrict room placement or out of room activities. 4. High-contact resident care activities include: g. Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes</p> <p>On 10/08/24 at 10:40 AM, observation revealed Registered Nurse (RN) #1 performed hand hygiene and used a barrier on overbed table for supplies. Resident #370's RN #1 accessed the Peripheral Inserted Central Catheter (PICC) line using standard precautions. EBP was not done during the administration of the medication. Observation also revealed no EBP sign posted on the room door for Resident #370.</p> <p>On 10/08/24 at 11:40 AM, an interview with RN #1 revealed she was unaware of the need to implement EBP for a resident with a PICC line.</p> <p>On 10/08/24 at 11:55 AM, an interview with the facility's Training Coordinator and Director of Nurses (DON) revealed the facility policy is for EBP to be used with central lines which would include Resident #370.</p> <p>Record review of Resident #370's Admission Record revealed the facility admitted the resident on 10/07/24.</p>