STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255273	A. BUILDING _____ B. WING _____	09/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILL NURSING CENTER	927 COOPER RD JACKSON, MS 39212

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Survey Agency (SA) conducted an annual recertification survey from 9/26/17 through 9/28/17. During the survey, the SA determined the facility was not in compliance with the Centers for Medicare and Medicaid Services Conditions of Participation. The SA cited deficiencies at F282, F315 and F441. The facility is licensed for 87 beds and the census at the time of survey was 75.	F 000		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to follow the comprehensive care plan for incontinent care for one (1) of 16 care plans reviewed; Resident #2. Findings include: A review of the facility's "Care Plans-Comprehensive" policy, not dated, noted: Our facility's Care Planning/Interdisciplinary Team, in coordination with the resident, his/her family or representative (sponsor), develops and maintains a comprehensive care plan for each	F 282	By submitting the enclosed material, Forest Hill Nursing Center is not admitting the truth or accuracy of any specific finding or allegations. Forest Hill Nursing Center reserves the right to contest the findings or allegations as part of any proceeding and submit these responses pursuant to our Regulatory Obligations. On 10/04/2017 The QA Committee meet to discuss the Corrective Actions to be taken to answer and correct the deficiencies found and noted on the Annual Survey. One of the topics	10/28/17

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

Electronically Signed | 10/22/2017

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255273	A. BUILDING _____ B. WING _____	09/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILL NURSING CENTER	927 COOPER RD JACKSON, MS 39212

(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 282	Continued From page 1 resident that identifies the highest level of functioning the resident may be expected to attain. Review of Resident #2's care plan, initiated 1/15/16, revealed she was incontinent of bowel and bladder. An approach included to provide good skin care/preventative skin care after each incontinent episode. Observation of incontinent care, on 9/27/17 at 10:40 AM, revealed Certified Nursing Assistant (CNA) #1 washed Resident #2's Perineal area from back to front. After CNA #1 assisted Resident #1 onto her right side she washed Resident #2's buttock areas from back to front and in a circular motion. CNA #1 then assisted Resident #2 onto her left side and washed her buttocks in a circular motion. On 9/27/17 at 11:50 AM, interview with the Minimum Data Set (MDS) Coordinator revealed, "No ma'am, she was not following the plan of care", when asked if CNA #1 had followed the plan of care for incontinent care for Resident #2. A review of the facility's Face Sheet revealed the facility admitted Resident #2 on 01/15/16, with diagnoses of Diabetes Mellitus, Asthma and Neoplasm of Kidney. A review of the most recent quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 8/15/17, revealed staff assessed Resident #2 with severe cognitive impairment.	F 282	discussed was Not Following A Resident's Personal Care Plan. The following Corrective Actions will be put into place to correct this deficiency: 1)The Unit 1 Nursing Staff was in-serviced on properly Following The Care Plan on 9/28/2017. The remaining Nursing Staff will be in-serviced by 10/28/2017 on properly Following the Care Plan. The CNA involved in this deficient practice was in-serviced on properly Following the Care Plan, but she became angry and resigned immediately. The Resident involved in this deficient practice was not harmed or caused any un-due illness. 2)On 9/28/17 a review was made by the ADON and Unit Manager to determine the number of Residents affected by this deficient practice. All residents in the facility have the potential of being affected by not following the Resident Care Plan. 3)The Unit Managers will Audit and review to determine the Plan of Care is being followed by the Direct Care Staff and Nursing Services. If deficient practices are found, the Direct Care Employee and/or the Nursing Staff Employee will be re-in serviced on following the Plan of Care and the Resident Care Plan. 4)All auditing of properly Following the Resident Care Plan and the Plan of Care will be brought to the QAPI Committee for review and determination if in fact these Corrective Actions are effective and if further Corrective Actions should be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255273	A. BUILDING _____ B. WING _____	09/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILL NURSING CENTER	927 COOPER RD JACKSON, MS 39212

(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 282	Continued From page 2	F 282	implemented.	
F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal	F 315		10/28/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255273	A. BUILDING _____ B. WING _____	09/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILL NURSING CENTER	927 COOPER RD JACKSON, MS 39212

(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 315	Continued From page 3 bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to provide incontinent care in a manner to prevent possible infection for one (1) of nine (9) care observations; Resident #2. Findings include: A review of the facility's "Perineal Care" policy, not dated, noted: "Wash perineal area wiping from front to back. Separate labia and wash area downward from front to back. Wash the rectal area thoroughly, wiping from the base of the labia towards and extending over the buttocks." On 9/27/17 at 10:40 AM, observation of Resident #2's incontinent care, provided by Certified Nursing Assistant (CNA) #1, revealed the CNA #1 washed Resident #2's perineal area from back to front. After CNA #1 assisted Resident #1 onto her right side she washed Resident #2's buttock area from back to front and in a circular motion. CNA #1 then assisted Resident #2 onto her left side and washed her buttocks in a circular motion. During an interview on 9/27/17 at 11:25 AM, CNA #1 stated, "I was recently checked off at the (name of the facility). I went back through the program to get my license, they had lapsed", when asked about training on incontinent care. CNA #1 stated she was supposed to wash "from front to back, but if I did that she would not be clean." CNA #1 stated, when asked what the concern would be wiping back to front and in a circular motion, "The problem is infection, you	F 315	On 10/04/2017 the QA Committee meet to discuss the Corrective Actions to be taken to correct the deficiencies found and noted on the Annual Survey. One of the topics discussed was Improper Perineal Care. The following Corrective Actions will be implemented to correct this deficiency. 1)Skill Check Offs were performed with the each Direct Care Worker located in this particular Resident Area by the Unit Manager on 09/28/17. Nursing Supervision attempted to in-service the Direct Care Worker involved in this deficient practice on 09/28/17, but she became angry and resigned her position. The Resident involved in this deficient practice was not harmed nor any suffering due to this deficient practice. 2)The ADON and Unit Manger reviewed each Resident located on this Resident Care Area on 09/28/17, and it was revealed 10 other Residents had the potential of being affected by this deficient practice. 3)Perineal Care Skills will be observed and audited monthly by the Unit Managers. Should a staff member be found to improperly perform Perineal Care, the staff member will be re-oriented in Perineal Care by the Unit managers and/ or the ADON.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255273	A. BUILDING _____ B. WING _____	09/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILL NURSING CENTER	927 COOPER RD JACKSON, MS 39212

(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 315	Continued From page 4 don't want contamination from going from one spot to another." CNA #1 stated that she was nervous at that point, when wiping from back to front and in a circular motion all over the areas during incontinent care. During an interview, on 9/27/17 at 11:55 AM, Licensed Practical Nurse (LPN) #3, stated, "She (CNA #1) should have wiped in a downward motion, never in a circle. She violated all of the infection control procedures, because she is wiping from dirty to clean", while providing incontinent care. A review of the facility's Face Sheet revealed the facility admitted Resident #2 on 01/15/16, with diagnoses of Diabetes Mellitus, Asthma and Neoplasm of Kidney. A review of the most recent quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/15/17, revealed the facility assessed Resident #2 with severe cognitive impairment.	F 315	4)Findings of the Monthly Observations and Audits will brought to the QAPI Committee for review and to make the determination if in fact the Corrective Action is effective. If found in-effective, the QAPI Committee will implement further Corrective Actions pertaining to this deficient practice. This will be an on-going corrective action.	
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual	F 441		10/28/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255273	A. BUILDING _____ B. WING _____	09/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILL NURSING CENTER	927 COOPER RD JACKSON, MS 39212

(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 441	Continued From page 5 arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255273	A. BUILDING _____ B. WING _____	09/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILL NURSING CENTER	927 COOPER RD JACKSON, MS 39212

(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 441	Continued From page 6 by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, facility staff failed to sanitize hands and handle bed linens in a manner to prevent contamination for Resident #2, and failed to handle feeding tube equipment to prevent infection for Unsampled A, for two (2) of nine (9) care observations. Findings include: A review of the facility's "Infection Control Guidelines for All Nursing Procedures" policy, not dated, noted: Employees must wash their hands for ten (10) to 15 seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: Before and after direct contact with residents and after removing gloves. A review of the facility's policy entitled "Administering Medications through an Enteral Tube" policy, not dated, noted: Wash your hands. Resident #2 Observation on 9/27/17 at 10:40 AM, revealed	F 441	On 10/04/2017 the QA Committee meet to discuss the Corrective Actions to be taken to correct the deficiencies found and noted during the Annual Survey. One of the topics discussed was Not Washing Hands Properly and Improperly Handling Linens causing cross contamination. The following Corrective Actions will be implemented to correct these deficient practices: 1)All staff involved in this deficient practice were in-serviced on the Infection Control Policy of the Facility. Specifically Proper hand Washing techniques on 09/28/2017. 2)A review was made by the ADON and Unit Manager on 09/28/17 to determine the number of Residents that possibly could be affected by this deficient practice. The review revealed 10 Residents ad the potential of being affected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255273	A. BUILDING _____ B. WING _____	09/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILL NURSING CENTER	927 COOPER RD JACKSON, MS 39212

(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 441	Continued From page 7 Certified Nursing Assistant (CNA) #1 did not wash her hands prior to beginning incontinent care on Resident #2. CNA #1 provided incontinent care to Resident #2 and then placed the soiled linens in a plastic bag and sat the bag on the floor. CNA #1 then picked up the plastic bag of soiled linens off of the floor and placed the bag in the resident's chair. During an interview on 9/27/17 at 11:25 AM, CNA #1 stated she should have washed her hands prior to providing Resident #2's incontinent care, "because I'm entering the room, germs is the importance, keeping down the germs. I was nervous." On 9/27/17 at 11:55 AM, Licensed Practical Nurse #3 stated that the soiled linen bag being placed on the floor was "cross contamination." LPN #3 also confirmed that not washing hands prior to providing incontinent care was an infection control issue. A review of the Face Sheet revealed the facility admitted Resident #2 on 01/15/16, with diagnoses of Diabetes Mellitus, Asthma and Neoplasm of Kidney. A review of the most recent quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/15/17, revealed staff assessed Resident #2 with severe cognitive impairment. Unsampled Resident A: On 9/26/17 at 8:20 AM, observation of LPN #1 revealed she did not wash her hands prior to feeding tube medication administration for Unsampled Resident A. After LPN #1 crushed Unsampled Resident A's medications and placed	F 441	3)All Nursing Staff and Direct Care Workers will be in-serviced on the facility's Infection Control Policy pertaining to Hand Washing and Storage of Linens by 10/28/2017. A weekly Audit of Hand Washing, Proper Storage and Infection Control will be made by the Unit Managers. If a Nursing Service Employee or a Direct Care Employee is found deficient in his/her practice they will be re-oriented to the facility's Infection Control Policy and Procedure by the Unit Managers and/or the ADON. These Audits will continue through 12/31/2017. 4)The weekly Audits of proper hand Washing, proper Storage and Infection Control will be brought monthly to the QAPI Committee for review. The QAPI Committee will determine if in fact these Corrective Actions are effective for this type of deficient practice. If found ineffective the Committee will implement further Corrective Actions pertaining to this deficient practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255273	A. BUILDING _____ B. WING _____	09/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILL NURSING CENTER	927 COOPER RD JACKSON, MS 39212

(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 441	Continued From page 8	F 441		

them in the plastic medication cup, she put the cups on the resident's nightstand with no barrier. While LPN #1 was rinsing the syringe, she placed the resident's plastic syringe bag on the resident's sink, with no barrier, in the bathroom. LPN #1 then put the syringe in the plastic bag and placed it back on the sink with no barrier, while she rinsed the plastic cup.

On 9/27/17 at 12:00 PM, LPN #3 confirmed cross contamination of putting the bag on the sink without a barrier while washing the syringe after medication administration for Resident #A.

During an interview on 9/28/17 at 10:25 AM, LPN #1 stated "I know when I put the plastic bag on the sink, that was contamination. LPN #1 stated she should always wash hands prior to beginning a procedure.

A review of the facility's Face Sheet revealed Unsampled Resident A was admitted on 7/5/16 with diagnoses of Nutritional Deficiency, Dysphagia, and Gastrostomy Status.

A review of Unsampled Resident A's most recent yearly MDS assessment with an ARD of 6/21/17, revealed staff assessed the resident with severe cognitive impairment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255273	A. BUILDING **01 - NEW WING (85) 01** B. WING _____	**09/28/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILL NURSING CENTER	**927 COOPER RD JACKSON, MS 39212**

(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
K 000	INITIAL COMMENTS 42 CFR 438.70(a) The facility must meet the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA) ...	K 000		
K 293 SS=D	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This STANDARD is not met as evidenced by: Based on observations, the facility failed to provide properly displayed exit signs as required by NFPA 101 section 7.10.1.1. This condition affected one (1) of five (5) smoke compartments and eight (8) of 75 residents in the facility at the time of survey. Findings include: Observations on September 28, 2017 at 11:17 AM revealed the required exit near Room 213 was not properly marked and labeled. The Maintenance Person stated the exit sign was removed because the exit door would not properly open due to the foundation shifting of the building.	K 293	FIRE SAFETY Received OCT 2 5 2017 MSDH-HFLC & CONSTRUCTION Accepted 10-26-17 Revisit By submitting the enclosed material, Forest Hill Nursing Center is not admitting the truth or accuracy of any specific finding or allegations. Forest Hill Nursing Center reserves the right to contest the findings or allegations as part of any proceeding and submit these responses pursuant to our regulatory obligations. On 10/04/2017 the QA Committee meet to discuss the Corrective Actions to be implemented to answer and correct the deficiencies found and noted on the Annual Survey. One of the topics discussed was Existing Exit Signage. The following Corrective Actions will be implemented to correct this deficiency: 1)Proper Exit signs have been placed on	10/22/17

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

Electronically Signed — 10/22/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255273	A. BUILDING **01 - NEW WING (85) 01** B. WING _____	**09/28/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILL NURSING CENTER	**927 COOPER RD JACKSON, MS 39212**

(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
K 293	Continued From page 1	K 293	the door and area pertaining to the exit door beside Resident Room 213. 2)An audit of all exit doors will be performed by the Maintenance Manager by 10/28/2017 to observe if proper exit signs are placed. If improper signage is found, proper signage will be placed by 10/28/2017. 3)A new door was hung on 10/20/2017 allowing proper opening and closing. 4)A monthly audit will be performed by the Maintenance Manager to assure proper exit signage and brought to the QA Committee monthly for review. 5)All residents have the potential of being affected by this deficient practice.	
K 363 SS=D	NFPA 101 Corridor - Doors Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable	K 363		10/22/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255273	A. BUILDING **01 - NEW WING (85) 01** B. WING _____	**09/28/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILL NURSING CENTER	**927 COOPER RD** **JACKSON, MS 39212**

(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
K 363	Continued From page 2 or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is not met as evidenced by: Based on observation and testing, the facility failed to properly protect corridor openings as directed by NFPA 101 section 19.3.6.3.5. This deficiency affected one (1) of the five (5) smoke compartments and 14 of 75 residents in the facility during the survey. Findings include: Observations on September 28, 2017 between 10:30 AM and 11:00 AM revealed the corridor doors to Patient Rooms 202, 207, 209, and 211 of the facility would not properly close and positive latch.	K 363	On 10/04/2017 the QA Committee meet to discuss the Corrective Actions to be taken to answer and correct the deficiencies found and noted on the Annual Survey. one of the topics discussed was Proper Protection Corridor Openings. The following Corrective Actions will be implemented to correct this deficiency. 1)Corridor Doors for Patient Rooms 202, 207, 209 and 211 have been adjusted to properly close. 2)An audit of all Corridor Doors for Patient Rooms will be performed by the Maintenance Manger by 10/28/2017 to determine is these doors properly close. If any door is found not to close properly, that door will be adjusted or replaced by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255273	A. BUILDING **01 - NEW WING (85) 01** B. WING _____	**09/28/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILL NURSING CENTER	**927 COOPER RD JACKSON, MS 39212**

(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
K 363	Continued From page 3	K 363	10/28/2017. 3)A monthly audit of all Corridor Doors to Patient Rooms will be performed by the Maintenance Manager and brought to the QA Committee for review and proper corrective action implementation. 4)All residents have the potential of being affected by this deficient practice.	