STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A402	A. BUILDING _____ B. WING _____	C 03/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JNH-JEFFERSON INN	3550 HWY 468 WEST WHITFIELD, MS 39193

(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 Agency (SA) conducted two (2) Complaint Investigations (CI MS #24292 and CI MS #24155) at the facility from 3/19/24 to 3/20/24. CI MS #24155 was investigated regarding resident rights, resident not being treated with dignity. CI MS #24292 was investigated regarding an unwitnessed fall. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid and cited F656 and F689. The facility held a license for 86 beds, with a census of 86.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).	F 656		5/1/24

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

Electronically Signed | 04/05/2024

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F 656	Continued From page 1 (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to ensure a Certified Nurse Aide (CNA) followed the resident's care plan, which resulted in an unwitnessed fall from the bed for one (1) of three (3) the residents reviewed for accidents. Resident #1 Findings include: Record review of "Care Plan," with a problem onset date of 5/10/2023 revealed : "Requires the use of Siderails x 2 in bed r/t (related to) Profound IDD (Intellectual and Developmental Disability),	F 656	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice On 2/23/2024, Resident #1 was assessed by the nurse no physical injuries were noted, and the neuro exam was normal. The nurse contacted the On Call Physician with this information, and she was instructed to follow the neuro checks protocol. Resident #1 was placed back in bed with her side rails up and locked.	

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F 656	Continued From page 2 Delusional Disorder, and Unaware of Safety Hazards ...Approaches ...Siderails up x 2 when in bed ..." On 3/20/24 at 11:02 AM, in an interview with the Administrator, she revealed CNA #1 did not follow Resident #1's care plan. The Administrator confirmed that she expects all staff to adhere to physician orders and to follow the resident's care plan, as the care plan is a guideline for how staff are to care for the residents and not following it puts the resident at harm. On 3/20/24 11:27 AM, in an interview with the Director of Nursing (DON), she revealed she has educated the CNA's on following the plan of care for resident care. She stated the ADL (Activities of Daily Living) guidebook, which is an extension of the care plan is specific to each resident's needs and is for CNAs to use while caring for their residents. She confirmed the siderail requirements, for Resident #1, were reflected in the guidebook, but CNA #1 did not follow the guidelines for the care of Resident #1. On 3/20/24 at 1:38 PM during the interview with CNA#1, she confirmed she uses the ADL guidebook to care for her residents and acknowledges the bedrail requirement for Resident #1 was in the guidebook. CNA #1 stated the night Resident #1 fell, she had decided to let the siderails down to prevent the resident from becoming agitated. On 3/20/24 at 2:13 PM, during a phone interview with Licensed Practical Nurse (LPN) #1, confirmed that she knows they must always follow the care plan. She said she assessed Resident #1 after the fall as per protocol, which	F 656	2. How the facility will identify other residents having the potential to be affected by the same deficient practice. The facility has determined by the census that 86 residents had the potential to be affected. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 03/20/2024, the Director of Nurses was verbally counseled by the Nursing Home Nurse Manager on understanding the need to follow the resident□s care plan and Physician orders as prescribed. Beginning 03/20/2024, the Director of Nurses in-serviced the nursing staff and certified nursing assistants on the importance of following the Physician orders as prescribed. Newly hired nursing and certified nursing assistant staff will be in-serviced upon hire, quarterly, and as needed by the Director of Nurses on the importance of following resident□s care plans and Physician orders. 4. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated in to the quality assurance system. Beginning on 03/22/2024, the Director of Nurses will monitor the nursing staff to address the issues and understanding of importance of following the resident□s	

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F 656	Continued From page 3 included such as vital signs and neuro checks. During her assessment she stated she noticed the siderails were down. A record review of the "Identification and Summary Sheet" revealed Resident #1 was admitted by the facility on 4/27/23. Her diagnoses included Delusional Disorder, Atrial Fibrillation and Hypertension.	F 656	care plan and Physician orders as prescribed two (2) times a week for one month, then one (1) time a month for one month, using the Physician□s Notes 24-hour chart check and the Facility□s Monthly Nursing Note. Any deficient practices will be corrected by the Director of Nurses. Beginning 03/27/2024, the Minimum Data Set Nurse will review the Resident□ Care Plan with the Treatment Team for revisions and improvements weekly. Beginning 03/29/2024 the Nursing Home Administrator will review audit documentation weekly for 30 days. Beginning on 04/04/2024, the Nursing Home Administrator will report all audit findings to the Quality Assurance Performance Improvement (QAPI) committee monthly for two (2) quarters for action until consistent substantial compliance has been achieved as determined by the committee. Should systemic changes not be effective QAPI will investigate and will determine if further action(s) need to be implemented. The actions from QAPI meeting will be reported to the JNH Executive Committee.	
F 689 SS=D	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.	F 689		5/1/24

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F 689	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on interviews, record review, facility investigation, and facility policy review, the facility failed to ensure a dependent resident was supervised and physician ordered assistive devices were implemented to prevent an unwitnessed fall from bed for one (1) of three (3) the residents reviewed for accidents. Resident #1 Findings include: Record review of the facility's policy titled, "Standards of Care," dated May 2022, revealed, "1. PURPOSE AND APPLICABILITY This policy identifies the designated nursing reference manual for licensed and unlicensed nursing staff ... in all programs ... 2. POLICY: ...The certified nursing assistant textbook currently in use by Staff Education is the designated reference manual for unlicensed nursing staff .... 3. PROCEDURE ... D. Prior to executing any clinical procedure, all nursing staff will: (1) Verify physician/nurse practitioner order for patient/resident ..." Record review of the "Investigative Findings," dated March 8, 2024, revealed the investigation of a fall involving Resident #1. The initial concern identified in the investigation was that the fall of Resident #1 may have been related to the resident's unexpected death, due to the close proximity of the two (2) events. However, through the facility's investigation, the facility determined that the death of Resident #1 was unrelated to the fall. Further review of the facility's investigation revealed that on February 23, 2024, the Certified Nurse Aide (CNA) assigned to her care, failed to follow the physician's orders related	F 689	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice On 02/23/2024, immediate action(s) taken for the resident(s) #1 found to have been affected. Resident #1 was assessed by the nurse no physical injuries were noted, and the neuro exam was normal. The nurse contacted the On Call Physician with this information, and she was instructed to follow the neuro checks protocol. Resident #1 was placed back in bed with her side rails up and locked. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. The facility has determined by the census that 86 residents had the potential to be affected. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 03/20/2024, the Director of Nurses was verbally counseled by the Nursing Home Nurse Manger on understanding the need to follow the resident□s care plan, Physician orders as prescribed and the importance of resident□s side rails being in place, locked and documented. Beginning 03/21/2024, the Director of Nurses in-serviced the nursing staff and certified nursing assistants on the importance of following the Physician Orders as prescribed and resident□s side	

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F 689	Continued From page 5 to the use of siderails when the resident was in bed. Record review of "RCA (Root Cause Analysis) Review" dated February 26,2024 revealed ...Concerns ...2. There was a physician's order for the bed's side rails to be up, but they were not ...Root Causes A. Fall The root cause for the resident's fall was the side rails of the bed were not raised in accordance with the physician's order ..." Record review of a handwritten Physicians Orders dated 2/9/24 revealed "Siderails x 2 when in bed R/T (related to) Profound IDD (Intellectual and Developmental Disability), Delusional Disorder, Does not foresee potential hazards x 30 days..." On 3/20/24 at 11:02 AM, in an interview with the Administrator she revealed that during their morning meeting, it was discovered that the CNA #1 put the siderails down while Resident #1 was in bed, which could have led to the fall of Resident #1. The Administrator revealed CNA #1 did not follow the physician orders and plan of care regarding the care of Resident #1. The Administrator stated she expects all staff to adhere to the physician orders. On 3/20/24 at 11:27 AM, in an interview with the Director of Nursing (DON), she revealed she has educated the CNA's on following the plan of care for residents. She stated the ADL (Activities of Daily Living) guidebook is specific to each resident's needs. The DON confirmed the CNAs are to use the guidebook, while caring for their residents. She confirmed that the siderail requirements for Resident #1 were reflected in	F 689	rails are to be in place and locked per Physician Orders. Newly hired nursing and certified nursing assistant staff will be in-serviced upon hire, quarterly, and as needed by the Director of Nurses on the importance of following side rail orders and resident□s safety. 4. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated in to the quality assurance system. Beginning on 03/20/2024, the Director of Nurses will monitor the nursing staff to address the issues and understanding of the importance of verifying that all residents that have orders for side rails are in place, locked and documented two (2) times a week for one month, then one (1) time a month for one month, using the Facility□s Side Rails Placement and Documentation Monitoring Audit Tool. Any deficient practices will be corrected by the Director of Nurses. Any bed equipment malfunction will be reported to the Coordinator of Unit Operations and the Facility Maintenance Department. Beginning 03/29/2024, the Nursing Home Administrator will review audit documentation weekly for 30 days. Beginning on 04/30/2024, the Nursing Home Administrator will report all audit findings to the Quality Assurance Performance Improvement (QAPI)	

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F 689	Continued From page 6 the guidebook, however, CNA #1 did not follow the guidebook. On 3/20/24 at 1:38 PM during the interview with CNA#1, she confirmed she has been caring for Resident #1 since she was admitted a year ago by the facility as well as the night the resident fell out of bed. She indicated she uses the ADL guidebook to care for her residents and acknowledges the bedrail requirement for Resident #1 was in the guidebook. However, she explains that the resident was the type of resident who would do whatever she wanted, regardless of trying to redirect her. The CNA stated that when the siderails were up, the resident would kick, hit, or spit or just try to climb over the rails altogether. So, the night she fell, the CNA had decided to let them down to prevent the resident from becoming agitated. CNA# 1 revealed she had not notified the nurse on duty about the resident's behaviors or that she had let the siderails down for Resident#1. On 3/20/24 at 2:13 PM, during a phone interview with Licensed Practical Nurse (LPN) #1, she confirmed she was working the night Resident #1 fell. She revealed CNA #1 had reported to her that she had found the resident sitting up on the floor with the sheets around her feet. She said she assessed the resident as per protocol, which included such as vital signs and neuro checks. During this time, she noticed the siderails were down but when questioning the CNA #1, she never got a clear answer about how the siderails got down. LPN#1 admits that she knows they must always follow the physician orders and that nurses must contact the physician before making any changes to the resident's care.	F 689	committee monthly for two (2) quarters for action until consistent substantial compliance has been achieved as determined by the committee. Should systemic changes not be effective QAPI will investigate and will determine if further action(s) need to be implemented. The actions from QAPI meeting will be reported to the JNH Executive Committee.	

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F 689	Continued From page 7 A record review of the "Identification and Summary Sheet," revealed the facility admitted Resident #1 on 4/27/23. Her diagnoses included Delusional Disorder, Atrial Fibrillation, and Hypertension. A record review of the Minimum Date Set (MDS), for Resident #1, with an Assessment Reference Date (ARD) of 1/25/24, revealed a Brief Interview for Mental Status (BIMS) score of 00, which indicated the resident had severe cognitive impairment.	F 689		