

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2019
NAME OF PROVIDER OR SUPPLIER FOREST HILL NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 Agency (SA) conducted an annual survey from 07/30/19 through 08/01/19. During the survey the SA determined the facility was not in compliance with the Medicare and Medicaid Requirements for participation. The SA cited deficiencies at F-600, F-602, F-641, F-657, F-658, F755 and F-880.	F 000			
F 600 SS=E	The facility was licensed for 87 beds, and had a census of 71 at the time of survey. Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, record review, and facility policy review, the facility failed to protect the residents from abuse for five (5) of six (6) residents reviewed for abuse. Residents #10, #24, #27, #28, and #60. Findings include:	F 600	F-600 1. On 6/6/19, Resident # 124 was immediately placed on one-on-one basis until transferred to Geri-Psych Unit on 6/6/19 at 5:33pm. Resident # 124 did not return to facility. On 7/28/19, the	9/3/19	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

08/30/2019

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2019
NAME OF PROVIDER OR SUPPLIER FOREST HILL NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 600	Continued From page 1 Review of the facility's policy, titled "Abuse/Neglect Reporting-Resident", no date, revealed each resident in this facility has the right to be free from verbal, sexual, mental, physical abuse, including corporal punishment, involuntary seclusion and/or misappropriation of property, Abuse is willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. This includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial wellbeing. Physical Abuse includes but is not limited to hitting, slapping, pinching, and kicking. It also includes controlling behavior through corporal punishment. Review of the facility's policy titled, "Preventing Resident Abuse", dated April 2013 revealed: "Our facility will not condone any form of resident abuse and will continually monitor our facilities (sic) policies, procedures, training programs, systems, etc. to assist in preventing resident abuse. Our abuse prevention/intervention includes but is not limited to assessing, care planning and monitoring residents with needs, and behaviors that may lead to conflict or neglect and involve qualified psychiatrists and other mental health professionals to help the staff manage difficult or aggressive residents. Review of the facility's policy titled, "Reporting Abuse to Facility Management" with no date, revealed: "It is the responsibility of our employees, facility consultants, Attending Physicians, family members, visitors, etc. to promptly report any incident or suspected incident of neglect or resident abuse, including injuries of	F 600	Administrator, Staff Development Nurse and Director of Nursing (DON) conducted an in-service on Abuse/Neglect/Reporting/Misappropriation . No employee will be allowed to work until In-serviced. On 7/31/19, Resident # 24 was transferred to Geri-Psych Unit for treatment. Resident returned 8/4/19, to a different room, with follow-up appointments for outpatient treatments. On 8/15/2019, Resident #60 was transferred to a separate hall. On 8/29/2019, the Quality Assurance (QA) Committee, consisting of Administrator, Medical Director, Director of Nursing/Infection Control Preventionist (DON), Social Services Director, Wound Care/Licensed Practical Nurse (LPN), Minimum Data Set (MDS)/Admissions Coordinator, Environmental Supervisor, Unit One Manager/ Registered Nurse (RN), Unit Two Manager/Registered Nurse (RN), Dietary Manager, Minimum Data Set (MDS) Coordinator, Medical Records Clerk/Licensed Practical Nurse (LPN), Therapy Supervisor, reviewed the policies for Preventing Resident Abuse, Abuse Investigation Reporting, Resident Rights and Resident to Resident Altercations with no recommended changes to the policy at this time. 2. All 71 Residents have the potential to be affected by this deficient practice. The facility Director of Nursing (DON) or Administrator will monitor all incidents for appropriate interventions and follow through beginning 8/2/19.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2019
NAME OF PROVIDER OR SUPPLIER FOREST HILL NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 600	Continued From page 2 unknown source and theft or misappropriation of resident property to facility management". Resident #10 Review of the facility's Resident Incident Report revealed an incident occurred, on 06/06/2019 at 8:46 AM, involving Resident #10 and Resident #124. The report stated Resident #124 entered Resident #10's room and began rummaging through her things. Resident #10 told Resident #124 to get out of her room, but instead he hit her on the side of her face with an open hand, knocking her back on her bed, and causing her eyeglasses to turn sideways. The Immediate Post-Incident Action stated Resident #124 was placed on one on one (1 on 1) supervision and taken to his room. Resident #10 was taken to an office and observed by a nurse. Orders were received to send Resident #12 to a Geri-Psych facility. The Incident Investigation section revealed the interviewed witness, (Certified Nursing Assistant (CNA) #1, stated the resident hit the female resident with an open hand to the left side of her face. The resident (Resident #124) fell to the floor after attempting to also hit the nurse who tried to intervene. An observation, on 07/31/19 at 1:53 PM, revealed Resident #10 was sitting on the bed reading a book. Resident #10 was alert and oriented, speech was clear, and she was able to make her needs known. During an interview, on 07/31/19 at 2:20 PM, Resident #10 revealed Resident #124 came in her room rambling through her stuff. Resident #10 said she told Resident #124 to get out of her room. Resident #10 said #124 punched her on	F 600	3. The facility Director of Nursing or Administrator will review and monitor all incidents. These will be logged daily and reviewed weekly in the High Risk Meetings to ensure appropriate interventions are in place. Any incident will be recorded on the Incident Monitoring Log for three months to ensure compliance. The Social Services Director will attend the Resident Council meeting every month beginning August 27, 2019 for six (6) months to note any issues of neglect, misappropriation of property and Resident Rights. Beginning on 9/09/19, Social Services Director will interview five (5) cognitively intact Residents per week for six (6) weeks for any issues with abuse, neglect, or misappropriation of property and documentation on the resident. 4. Any concerns will be addressed immediately by the Administrator and findings will be brought to the Quality Assurance Committee quarterly for compliance and recommendations.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2019
NAME OF PROVIDER OR SUPPLIER FOREST HILL NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 600	Continued From page 3 the left side of her face. Resident #10 said Resident #124 hit her so hard she fell on the bed and it turned her glasses sideways. During an interview, on 07/31/19 at 2:21 PM, Certified Nursing Assistant (CNA) #1 said she was walking down the hall and overheard Resident #10 say get out of my room. She saw Resident #124 punch Resident #10 on the left side of her face. Resident #10 fell to the bed. Resident #124 started rambling through Resident #10's night stand. CNA #1 said she attempted to redirect Resident #124, but Resident #124 started swinging at CNA #1. CNA #1 went to the door and yelled for Licensed Practical Nurse (LPN) #5 to assist her. Resident #124 started swinging at LPN #5. CNA #1 went to get the Director of Nurses (DON) and the Assistant Director of Nurses (ADON). Resident #124 kept swinging at LPN #5 until he fell on the floor. CNA #1 said Resident #124 was sent out to the Geri Psych Unit, that Resident #124 did not return to the facility. During an interview, on 07/31/19 at 2:29 PM, LPN #5 said CNA #1 yelled for help. LPN #5 said she came to the room and asked Resident #124 to come out of Resident #10's room. Resident #124 refuse to be redirected. Resident #124 started swinging at her. CNA #1 went to get the DON and ADON. Resident #124 kept swinging until he fell on the floor. LPN #5 said Resident #124 was sent to Geri Psych. Record review of Resident #124's Comprehensive Care Plan revealed the following Problems/Needs: 05/21/19, Urinary Tract Infection (UTI) infection with increased confusion. The Goal & Target Date was 07/20/19, the UTI	F 600			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2019
NAME OF PROVIDER OR SUPPLIER FOREST HILL NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 600	Continued From page 4 will be resolved before the next review date. Approaches included: Orient resident to self, place, and situation due to acute changes in behavior and increased confusion. 10/30/18, Resident has poor short term memory and cannot recall/repeat given words or phrases from memory. The Goal & Target Date was 07/20/19, will continue to function at highest practical level without (w/o) further preventable decline throughout next review date. Approaches included: Encourage him to participate in activities of interest. Provide one on one interaction to provide stimulation for cognitive status awareness. Give him opportunities to make simple decision for himself and give the time to do so. Provide cues and supervision. 01/30/19. Potential for socially inappropriate behavior r/t his diagnosis of Vascular Dementia with Behavior Disturbances and Unspecified Psychosis. The Goal & Target Date was 07/20/19, will have less than 2 (two) episode of inappropriate behavior per month. Approaches included: Do not argue with resident. Remove resident from public area when behavior is inappropriate. Provide diversional activities as needed Assist resident in avoiding situation that will result in inappropriate behavior. 10/30/1, Potential to become withdrawn. The Goal & Target Date was 07/20/19, will socialize/participate in at least 2 (two) activities a month. Approaches included: Monitor and record mood/behavior changes Q (every) shift. Encourage resident to attend activities with friends. Speak in an understanding non-judge mental tone of voice when communicating with the resident. Further review of the Resident Incident Reports revealed: On 05/15/18 at 8:20 PM, Resident #124	F 600			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2019
NAME OF PROVIDER OR SUPPLIER FOREST HILL NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 600	Continued From page 5 had a physical altercation with another resident. Resident #124 stated he did not know what the staff member was talking about when he was asked what had happened. The Medical Doctor (MD) was notified, no new orders were received. The Immediate Post-Incident Action revealed the residents would remain separated to prevent further occurrences. On 07/20/18 at 11:00 AM, Resident #124 was punched and knocked down to the floor by another resident. The other resident accused Resident #124 of having his jacket, which he did not. The jacket was checked and found to have Resident #124' name on it. Body audit was done, and Resident #124 was assessed, no bruising was found, and no complaints of any pain. The Immediate Post-Incident Action stated the residents were separate immediately and the assailant resident was sent out to Geri-Psych for evaluation. On 05/31/19 at 7:10 PM, Resident #124 punched another resident in the arm. Resident #124 could not remember the incident happening, when he was questioned by the facility staff. A Certified Nursing Assistant (CNA) stated the other resident was trying to get something out of Resident #124's pocket, and he told the other resident to stop, but he didn't, and Resident #124 punched the other resident on the arm. The Immediate Post-Incident Action stated the residents were immediately separated and will remain separated to prevent future occurrences. During an interview, on 07/31/19 at 3:18 PM, the Administrator confirmed Resident #124 punched Resident #10 in the face. The Administrator said she was trying to find placement for Resident #124 because of his aggressive behavior. The Administrator said she was aware of Resident 124 attempting to fight staff and refusing to be	F 600			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2019
NAME OF PROVIDER OR SUPPLIER FOREST HILL NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 600	Continued From page 6 redirected. Record review of Resident #10's Comprehensive Care Plan, no date, revealed Resident #10 was at risk for high anxiety and has a fear that others around her are upset with her easily evidenced by constantly asking everyone are you upset with me today?" Will repeatedly state I'm sorry for no reason. Interventions included: Encourage resident to participate in daily activities to spend time with friends, Ensure Resident that no one is angry or upset with her to relieve stress, redirect resident if she becomes overly anxious and is on the verge of becoming tearful. Resident #10 has a diagnosis of unspecified Dementia, Unspecified Psychosis, Major Depressive Disorder, and Anxiety, resident is often repetitive in questions and has episodes if anxiety, Resident #10 has memory loss and distortion. Resident #10 enjoys special attention and one on one conversations with staff. Resident is at risk for falls related to (r/t) poor safety awareness, depression and anxiety. A review of the Face Sheet revealed the facility admitted Resident #10, on 09/11/2017 with diagnoses, which included the included diagnoses Depressive Disorder, Dementia and Anxiety Disorder. A review of Resident #10's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/8/2019, revealed Resident #10 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. A review of the Face Sheet revealed the facility admitted Resident #124, on 09/11/2017, with	F 600			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2019
NAME OF PROVIDER OR SUPPLIER FOREST HILL NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 600	Continued From page 7 diagnoses which included Vascular Dementia, Psychosis and Major Depressive Disorder. A review of Resident #124's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/6/2019, revealed Resident #124 had a Brief Interview for Mental Status (BIMS) score of 5, which indicated the resident was severely cognitively impaired. Resident #28 and Resident #60 Review of the Resident Incident Reports revealed, on 03/19/19 at 8:48 AM, an altercation occurred between Resident #28 and another resident (#60). The CNA (#6) reported a resident (#28) came into the bathroom while Resident #60 was finishing up their shower. The Resident #60, who was dressing, became very angry and slammed the door in (Name of Resident #28's) face. At this point Resident #28 grew angry, came inside and punched Resident #60. The CNA was able to stop the men from fighting and separate the two individuals. There were no injuries to either party. The Immediate Post-Incident Action stated the two individuals were separated and taken to separate units. Both individuals were interviewed, and witness involved, and assessed both residents for injuries. The Narrative of Investigation stated the incident was investigated and no injuries found. Both residents deny being hit by the other person. Both agreed to stay away from each other, and each stated they do not dislike each other. Review of the facility's Report Information, an investigative document provided by the facility Administrator, dated 03/21/19, revealed an incident occurred on 03/19/19 between Resident	F 600			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2019
NAME OF PROVIDER OR SUPPLIER FOREST HILL NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 600	Continued From page 8 #28 and Resident #60. Certified Nursing Aide (CNA) #6 was assisting Resident #60 with getting dressed after he finished his shower then Resident #28 knocked on the door. CNA #6 said patient care, but Resident #28 still opened the door. Resident #60 closed the door on Resident #28 and Resident #28 opened the door again and told Resident #60 that if he closed the door again, he was going to bust his head. Resident #60 closed the door again and that's when Resident #28 opened the door and he was swinging his fist at Resident #60. Resident #60 was swinging back and then landed punches on one another. CNA #6 intervened and started yelling for help. Neither Resident #28 nor Resident #60 received any injuries, no hits to the head. The document stated that the physician was notified, on 03/19/19, for each resident, but neither was seen by a physician since there was no notice of any signs of injury. The document also revealed that the Resident Representative was notified for both Resident #28 and Resident #60. On 07/31/19 at 3:20 PM, the surveyor attempted to call CNA #6 twice with no answer, and no voice mail set up. Record review of CNA #6's Witness Statement, dated 03/19/19, revealed CNA #6 stated "I was assisting Resident #60 with getting dressed after his shower when Resident #28 knocked on the door. I said patient care, but Resident #28 opened the door. Resident #60 closed the door on Resident #28. Resident #28 opened the door again and told Resident #60 if he closed the door again, he was going to bust his head. Resident #60 closed the door again and that's when Resident #28 opened it up and with his fist closed and swinging at Resident #60. Resident #60	F 600			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2019
NAME OF PROVIDER OR SUPPLIER FOREST HILL NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 600	Continued From page 9 swung back and they both landed a punch on one another. I intervened and started yelling for help. That's when three (3) of my co-workers came and the incident ended". An observation, on 07/31/19 at 4:00 PM, revealed Resident #28 and Resident #60 shared a hall shower with other residents at the facility. An observation, on 08/01/19 at 9:00AM, revealed Resident #28 and #60's rooms were located side by side on the unit with the shower room across the hall from the resident's rooms. Record review of the Face Sheet revealed Resident #28 currently resided in room 212B. Record Review of the Face Sheet revealed Resident #60 currently resided in room 214B Review of a document provided by the facility revealed Resident #28 was placed in room 212B on admission, 05/16/14. Resident #60 was placed in room 214B on 11/14/18. Record review of the Minimum Data Set (MDS), with an ARD date of 03/21/19, revealed Resident #28 had a Brief Interview of Mental Status (BIM)S score of 15, which indicated no cognitive impairment. Further review of the MDS revealed no concerns with behaviors was identified. Record Review of the MDS, with an ARD date of 03/21/19, revealed Resident #60's BIMS score was 9, which indicated moderate cognitive impairment. Further review of the MDS revealed no concerns with behaviors was identified. An interview, on 07/31/19 at 10:37 AM, with	F 600			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2019
NAME OF PROVIDER OR SUPPLIER FOREST HILL NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 600	Continued From page 10 Administrator revealed, "If I remember correctly that's the incident where Resident #28 knocked on the door in the shower room. CNA #6 was in there and she separated them at that time. Basically, we need to make sure the residents know if care is in progress they have to wait. We have two other bathrooms down that hall and some of the residents have bathrooms in their room. The shower room is used by everyone on that unit. We have had no other incidents since then with these two residents. They were separated in the shower that day. I'll have to check and see if anything else was done. I guess I should have got the Psychiatric Nurse Practitioner to evaluate the residents and moved rooms with one of them. To my knowledge, Resident #28 was never seen by the facility's Psych Nurse Practitioner and I believe Resident #60 was not seen by the Psych Nurse Practitioner until June 2019 after the incident". An interview, on 07/31/19 at 9:10 AM, with Registered Nurse (RN) #1 revealed CNA #6 was in the shower the day of the incident between Resident #28 and Resident #60. RN #1 stated however CNA #6 had quit and walked out of the building this morning after coming to work. An interview, on 08/01/19 at 4:34 PM, revealed the DON stated, in my opinion based on the evidence presented to me, I feel neither Resident was protected from reoccurrence. An interview, on 08/01/19 at 2:55 PM, with the Administrator revealed, "I don't really know what time they called and told me about the incident. We did separate them for a little while that day, but we did allow them to go back to their room the same day since there was no more incidents.	F 600			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2019
NAME OF PROVIDER OR SUPPLIER FOREST HILL NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 600	Continued From page 11 They do still share a bathroom and shower room." The Administrator further revealed the residents are in the same room they were in at the time of the incident. The Administrator stated, "I'm not sure what time I was notified of the incident. I don't have any documentation where I wrote down when I was notified, nor the instructions I gave them. I'd have to review my notes. You've got all my documentation from that day." Resident #24 Review of the facility's Report Information, signed by the Administrator, and no date revealed a reported incident and brief description of an altercation between Resident #24 and another resident. The Brief Description of the event stated another resident lightly hit Resident #24 on the arm and Resident #24 hit another resident in the face, another resident has skin tears on the right side of the right eye, on his jaw, and on the right side of his neck. Review of the facility's investigation documented on the Information Report revealed, on July 14, 2019 it was reported that Resident #24 had hit another resident. "Upon investigation into this incident, on July 14, 2019 around 3:19 PM, another resident entered the activity room. Another resident took a chair from one table and placed it at another table nearby. Before he could sit, a female resident grabbed the chair returning it to the original table and sat down. Another resident went to retrieve another chair. After getting it, another resident pushed his walker with one hand and pulled the chair with the other. Resident #24 came into the activity room and had his arms over the shoulder of the female resident.	F 600			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2019
NAME OF PROVIDER OR SUPPLIER FOREST HILL NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 600	Continued From page 12 Another resident came back toward the table, but the tables were in close proximity and the other resident could not get through. It appears that another resident touched Resident #24 with his walker. Resident #24 pushed another resident's walker causing his drink to spill. Another resident balled up his fist and touched Resident #24 on the arm. Resident #24 got in another resident face and hit him. Resident #24 lost his balance and fell to the floor. The other resident did not fall. Both residents were separated, and both have been referred for evaluation by Psych services. The other resident was evaluated by the nurse, but Resident #24 refused to be evaluated. The physician was called and both RP were notified. No other incidents have occurred. This completes the investigation." Review of the Narrative of Incident revealed, "This nurse was at unit one nurses station doing CNA assignments when loud noises came from activity room where Residents were lining up to smoke. This nurse ran into room. Noted that Resident was sitting in a chair at the table, in front of the table was spilled drinks and the walker of another resident. When asked what happened Resident stated, "I did not hit him". This nurse asked him who, Resident then pointed at another resident. This nurse asked him to explain what happened, Resident would not. Immediate Post-Incident Action: Other resident taken out with unit 2 staff to smoke without having to come onto same hall as this resident. Residents were immediately separated." On 07/30/19 at 10:10 AM, with Resident # 24 regarding his incident with another resident, revealed Resident #24 stated another resident	F 600			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2019
NAME OF PROVIDER OR SUPPLIER FOREST HILL NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 600	Continued From page 13 popped him on his back, so then he attacked the other resident, the other resident is no longer in facility, according to the Resident #24. Review of the Care Plan for the Problem/Need, dated, 09/10/2018, revealed Resident #24 displays physically aggressive behavior at times. The approaches included: Identify causes for behavior and reduce factors that may provoke Resident #24. Discuss Resident #24 options for appropriate channeling of anger. Talk with Resident #24 in calm voice when behavior is disruptive. Remove Resident #24 from public area when behavior is disruptive and unacceptable. On 07/31/19 at 2:36 PM, an interview with Certified Nurse Assistant (CNA) # 2, revealed normally Resident #24 is in bed and if there was an altercation the other resident had to set him off, he normally helps all the residents out. On 08/01/2019 at 12:47 PM, with the DON, revealed Resident #24 may have a temper at intervals, and he has been transferred to Geri-Psych Hospital. On 08/01/2019 at 1:00 PM, an interview with the DON, revealed the other resident involved in the facility reported investigation was also admitted to Geri-Psych Hospital. On 08/01/2019 at 1:10 PM, the surveyor attempted to contact both of the Resident's Representatives regarding the facility's reported incidents, however did not receive any return calls. On 08/01/19 at 4:33 PM, an interview with the	F 600			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2019
NAME OF PROVIDER OR SUPPLIER FOREST HILL NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 600	Continued From page 14 Director of Nursing, revealed Resident #24 would become very agitated with his room-mates. Review of the Face Sheet revealed the facility admitted Resident #24, on 09/10/18, with included diagnoses Acute Upper Respiratory Infection and Pain. Review of Resident #24's Quarterly MDS, with an ARD date of 03//13/19, revealed a BIMS score of 15, which indicated no cognitive impairment, and no behavior concerns were identified. Resident #27: Review of the facility's Report Information signed by the Administrator, no date, revealed, on 06/27/19, the facility's Receptionist stepped into the office and reported to the Administrator in the presence of the Dietary Manager she had observed a resident swinging at Resident #27, and she wanted to report it. The Receptionist stated she had pushed the resident up the hill, and there was no contact made. On July 1, 2019, it was discovered that no incident report had been made. Further investigation found that (Name of Receptionist) had not reported the incident to the nurse. Therefore, the incident was immediately reported to the Mississippi State Department of Health and the Mississippi Attorney General's Office. Statements were gathered from staff from that day. The Receptionist stated she was coming through the side doorway toward Unit #1 to clock in from lunch. According to the Witness Statement, the Receptionist stated she saw the resident hit Resident #27 in the face three times. Witness statement was not written until 07/01/19. The Receptionist reported to the Administrator and the Dietary Manager no contact was made.	F 600			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2019
NAME OF PROVIDER OR SUPPLIER FOREST HILL NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 600	Continued From page 15 Camera footage was not available for this incident. On June 27, 2019, immediately after this event, Resident #27 went to smoke. (Name of Staff Member) gave Resident #27 her cigarette and saw no injury. Following smoking, Resident #27 went to activities, and the Activities Director said she did not see any injury. This completes the investigation. Review of the Brief Description of the event, documented on the Report Information, revealed Resident on Resident altercation - Employee Receptionist reported seeing another resident was swinging at Resident #27. The following investigation from June 27, 2019 where no injuries were noted. Record review of the Departmental Notes-Nursing, dated 07/01/2019 at 4:14 PM, revealed a Resident on resident incident, which occurred on 6/25/2019. Reported by employee to administration at the time of incident. Resident was observed being punched in the face x three (3) by another resident. Staff member stated that both residents were propelling their wheelchairs in the hallway. On the hill, on unit one. Resident was rolling down the hill. When she punched resident in the face x three (3). The nurse's note on 07/01/2019, revealed no apparent injuries to the face area. On 07/31/19 at 5:00 PM, an interview with Resident # 27, about being punched in the face, revealed she gave a thumb's up, for no injuries. On 07/31/19 at 5:05 PM, an interview with the Administrator revealed the resident was slapped in the face by another resident and she had no injuries. The Administrator stated she reported	F 600			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2019
NAME OF PROVIDER OR SUPPLIER FOREST HILL NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 600	Continued From page 16 the injury to the Department of Health. On 08/01/2019 at 12:47 PM, an interview with the DON, revealed Resident #27 very mild mannered. On 08/01/2019 at 3:10 PM the surveyor contacted Responsible Party and they revealed they were informed of the incident.	F 600			
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to protect the Resident #24's property from unauthorized use of funds for one (1) of 21 residents reviewed for misappropriation of funds. Findings Include: Review of the facility's policy, titled Investigating Incidents of Theft and/or Misappropriation of Resident Property. The policy statement revealed all reports of theft or misappropriation of resident property shall be promptly and thoroughly investigated. The policy Interpretation and Implementation revealed the residents have the right to be free from theft and/or misappropriation	F 602	F-602 1. On 4/24/19, Resident # 24 was given \$35.00 to replace the Resident s funds. On 7/28/19, the Administrator, Staff Development Nurse and Director of Nursing (DON) conducted an in-service on Abuse/Neglect/Reporting/Misappropriation and Resident Rights. On 8/29/2019, the Quality Assurance (QA) Committee, consisting of Administrator, Medical Director, Director of Nursing/Infection Control Preventionist (DON), Social Services Director, Wound Care/Licensed Practical Nurse (LPN), Minimum Data Set	9/3/19	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2019
NAME OF PROVIDER OR SUPPLIER FOREST HILL NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 602	Continued From page 17 of personal property. Misappropriation of resident property, " is defined as deliberate misplacement, exploitation, or wrongful, temporary or permanent use of resident's belongings or money without resident's consent. Our facility will exercise reasonable care to protect the resident from property loss or theft, including: Implementing policies that strictly prohibit, and pursue to the full extent of the law, staff, staff or employee theft or misappropriation of resident property. Review of the facility's Complaint-Incident reported to the Mississippi State Department of Health, on 04/24/2019 at 1:19 PM, by the Administrator, revealed it was reported this AM, Resident #24 had given money (Name of Dietary Staff #2), an ex-dietary worker. The Administrator interviewed Resident #24, and he said that (Dietary Staff #2) had asked him for money, but he could not remember the time or day that this took place. Resident #24 said he was trying to help Dietary Staff #2. Dietary Staff #2 said Resident #24 gave her the money, she did not ask the resident for the money. Dietary Staff #2 said she tried to find a nurse to give the money to, but she was not able to find one, and put the money in her car. Dietary Staff #2 said she had forgotten about it, until I spoke with her this morning. Dietary Staff #2 is out of state, so she sent the money via a money cable service for me to pick up. Review of the typed note, dated Wed, Apr 24, 2019 (Wednesday, April 24, 2019), and signed by the Dietary Manager revealed, "Today and employee approached me and explained that I might want to "look into a dietary employee borrowing money from a resident, (Name of Resident #24)." I spoke with (Name of Resident	F 602	(MDS)/Admissions Coordinator, Environmental Supervisor, Unit One Manager/ Registered Nurse (RN), Unit Two Manager/Registered Nurse (RN), Dietary Manager, Minimum Data Set (MDS) Coordinator, Medical Records Clerk/Licensed Practical Nurse (LPN), Therapy Supervisor, reviewed the policies for Preventing Resident Abuse, Abuse Investigation Reporting, Resident Rights and Resident to Resident Altercations with no recommended changes to the policy at this time. 2. All 71 Residents residing in this facility have the potential to be affected by the same deficient practice. On 8/27/19, the Social Service Director met with Resident Council and discussed abuse, neglect, and misappropriation of funds. The Social Services Director also discussed means of securing funds by utilizing the Resident Trust Fund. 3. On 7/28/2019, the Administrator, Director of Nursing (DON) and Staff Development Nurse began in-service for all staff on Abuse, Neglect, Misappropriation and Resident Rights. No staff will be allowed to work until in-service is completed. On 8/27/19, the Social Service Director spoke to Resident Council Committee regarding this facility's policy and procedures on Abuse/Neglect/Misappropriation of Property and Resident Rights. The Resident Council authorized the Social Service Director to attend their monthly meeting to check on any issues on abuse, neglect, and misappropriation of property		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2019
NAME OF PROVIDER OR SUPPLIER FOREST HILL NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 602	Continued From page 18 #24 on this matter and he said (Name of Dietary Staff #2) did indeed borrow \$25-\$35 cash ...He couldn't remember the exact amount. I explained to him that any employee should not ask for help from a resident. I explained that I understood him wanting to help but if any employee needed help they could come to me (Name of Dietary Manager) or the Administrator, (Name of Administrator). Furthermore, (Name of Dietary Staff #2 no longer works for this facility. Review of training provided to Dietary Staff #2, dated 02/14/19, revealed a copy of the facility's policy, Abuse and Neglect-Reporting-Resident, which also included Misappropriation of Resident Property, and identified the Seven Types of Abuse. Further review of the training revealed Dietary Staff #2 signed a document, on 02/04/19 stating, I have completed viewing the Hand N Hand series. Review of the facility's Grievance/Complaint Form, dated 04/24/19, revealed Resident #24 filed a grievance stating an employee came to him and stated she need to talk to him later. She came back later and asked him to borrow \$25.00. Resident #24 said he wanted his money back. Review of the facility's Grievance/Complaint Investigation Report Form, dated 04/24/19, revealed Resident #24 said the incident occurred in March 2019. Resident #24 said the employee came to him and said she needed to talk to him later, and she returned later and asked to borrow \$25.00. Resident #24 said he gave it to her. The findings for the incident revealed the facility was unable to validate the incident, and did recommend returning the resident's money. Resident #24 signed the document on 04/24/19,	F 602	and Resident Rights for six (6) months. 4. The Social Service Director will attend the Resident Council meetings every month for six (6) months to note any issues of abuse, neglect, and misappropriation of property and resident rights for six (6) months. This will be logged on the Resident s Council meeting minutes. The Social Service Director beginning 9/19/19, will interview five (5) cognitively intact residents per week for six (6) weeks for any issues with abuse, neglect or misappropriation of property and document on the Resident Misappropriation/Abuse/Neglect Interview Log. Any concerns will be addressed immediately by the Administrator and findings will be brought to the Quality Assurance Committee quarterly for compliance and recommendations.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2019
NAME OF PROVIDER OR SUPPLIER FOREST HILL NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 602	Continued From page 19 and checked yes for was the grievance/complaint resolved to satisfaction of all concerns. During an interview, on 08/01/19 at 2:54 PM, the DM confirmed Dietary Staff #2 did borrow \$35.00 from Resident #24. The DM said Resident #24 asked him, where is Dietary Staff #2. He told Resident #24 Dietary Staff #2 moved to (Name of State). Resident #24 said he loaned her money and wanted it back. Resident #24 said he was trying to help her. The DM said he notified the Administrator. During an interview, on 08/01/19 at 3:01 PM, the Administrator confirmed Dietary Staff #2 borrowed money from Resident #24. The Administrator said she called Dietary Staff #2 and asked her about the money. The Administrator stated Dietary Staff #2 said she did not borrow the money, and that Resident #24 gave her the money. Dietary Staff #2 said she attempted to give the money to a nurse, but could not find one in the building. Dietary Staff #2 said she put it in her glove box. The Administrator told her to return Resident #24's money. Dietary Staff #2 said that she was in (Name of State). Dietary Staff #2 sent \$35.00 via (Name of Store) to the Administrator. The Administrator said she reported this to the Attorney General's office. A review of the Face Sheet revealed the facility admitted Resident #24, on 09/10/2018, with diagnoses which included Asymptomatic Human Immunodeficiency Virus Infection, Cerebrovascular Accident and Pain. A review of Resident #24's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD), of 03/19/2019, revealed Resident	F 602			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2019
NAME OF PROVIDER OR SUPPLIER FOREST HILL NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 602	Continued From page 20 #24 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact.	F 602			
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on facility policy review, record review, and staff interview, the facility failed to accurately code Resident #74's Minimum Data Set (MDS) related to discharge for one (1) of three (3) resident MDS record reviews. Findings include: A review of the Resident Assessment Instrument (RAI) Policy Statement, revised September 2010, revealed comprehensive assessment of a resident's needs shall be made within fourteen (14) days of the resident's admission. The Policy Interpretation and Implementation stated 1. The Assessment Coordinator is responsible for ensuring that the Interdisciplinary Assessment Team conduct timely resident assessments and reviews according to the following schedule: B. when there has been a significant change in the resident's condition. 2. The Interdisciplinary Assessment Team must use the MDS form currently mandated by Federal and State regulations to conduct the resident assessment. Other assessments forms may be used in addition to the MDS form. A review of the most recent MDS, with an	F 641	F641 1. Minimum Data Set (MDS) Nurse #1 and Minimum Date Set (MDS) Nurse #2 were inserviced on the importance of accuracy of assessments by the Director of Nursing (DON) on 8/2/19. A corrected assessment was completed on 8/13/19 and transmitted and accepted per validation report on 8/14/2019. 2. All residents that require a Minimum Data Set (MDS) have the potential to be affected by this deficient practice. On 8/29/2019, the Quality Assurance (QA) Committee, consisting of Administrator, Medical Director, Director of Nursing/Infection Control Preventionist (DON), Social Services Director, Wound Care/Licensed Practical Nurse (LPN), Minimum Data Set (MDS)/Admissions Coordinator, Environmental Supervisor, Unit One Manager/ Registered Nurse (RN), Unit Two Manager/Registered Nurse (RN) Dietary Manager, Minimum Data Set (MDS) Coordinator, Medical Records Clerk/Licensed Practical Nurse (LPN), Therapy Supervisor, reviewed the	9/3/19	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2019
NAME OF PROVIDER OR SUPPLIER FOREST HILL NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 641	Continued From page 21 Assessment Reference Date (ARD) of 06/24/2019, revealed a Discharge End of Perspective Payment System (PPS) Assessment Return not anticipated was coded with the discharge status being acute hospital. Review of the Departmental Notes-Nursing, dated 06/24/2019, revealed Resident #74 was discharged from the facility on 06/24/2019, to home. A review of the Physician's Order, dated 06/24/2019, revealed Resident #74 was discharged to home with home health services. On 07/31/19 at 4:25 PM, an interview with Licensed Practical Nurse (LPN) #3/MDS Coordinator, revealed according to the MDS, dated 06/24/2019, Resident #74 was admitted to an acute hospital, but actually he was discharged home. LPN #3/MDS Coordinator confirmed the MDS was coded incorrect. On 08/01/2019 at 8:39 AM, an interview with the Director of Nursing (DON), revealed since she was new to the facility, she was unaware of his discharge but, the MDS should have been coded accurately.	F 641	policy and procedure for Certifying Accuracy of the Resident Assessment and Resident Assessment Instrument with no recommended changes at this time. 3. On 8/29/19, the Director of Nursing (DON) will begin audit of five (5) Minimum Data Set (MDS) titled Identification Information Assessments per week for six (6) weeks for accuracy of Section A and document on the Accuracy of Assessment Audit Log. 4. Any concerns will be addressed immediately. These will be logged and followed weekly at High Risk meeting to ensure appropriate interventions are in place. Findings will be brought to the Quality Assurance (QA) Committee quarterly for compliance and recommendations.		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to--	F 657		9/3/19	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2019
NAME OF PROVIDER OR SUPPLIER FOREST HILL NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 657	Continued From page 22 (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, record review, and facility policy review, the facility failed to revise the comprehensive care plan related to falls for one (1) of 21 resident care plans reviewed. Resident #37. Findings include: A review of the facility's policy titled, "Care Plans, Comprehensive Person-Centered", dated December 2016 revealed, the Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. A review of the facility's policy titled, "Falls and	F 657	F657 1. On 8/02/2019, the care plan for Resident # 37 was amended to reflect the current status of the resident by Director of Nursing (DON). 2. All residents with a history of falls have the potential to be affected by this deficient practice. On 8/26/19, the Director of Nursing (DON) assessed sixteen (16) Residents with falls in the last three (3) months. On 8/29/2019, the Quality Assurance (QA) Committee, consisting of, Administrator, Medical Director, Director of Nursing/Infection Control Preventionist (DON), Social Services Director, Wound Care/Licensed		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2019
NAME OF PROVIDER OR SUPPLIER FOREST HILL NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 657	Continued From page 23 Fall Risk Managing", dated December 2007, revealed if falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remain relevant. Review of Resident #37's Care Plan with the Problem/Need, dated 04/11/18, revealed the resident was at risk for injury related to frequent falls. The Goal & Target Date stated he would not experience any injuries from falls, 09/09/19. The Approaches with no dated included: Start Neuro Checks if the resident hit his head. Make sure resident has on appropriate shoes daily, like tennis shoes to ensure safety during transfer. Adequate lighting in room. Staff observe and assist with transfers. Approaches dated 06/07/19 through 07/29/19 included: Toilet every two hours. Ensure items are within reach. Check every two hours and as needed to ensure the resident is clean and dry. Change clothes as needed. Provide a low bed to minimize injuries when a fall occurs. Change side rails to ¼ side rails. Review of Resident #37's Fall Risk assessment, dated 03/15/19, revealed he scored 16 (10 or greater indicated high risk for falls) on assessment, which indicated he was at high risk for falls. On 07/30/19 at 10:46 AM, an observation revealed Resident #37 sitting in his wheelchair in the Activity Room. A record review of the most recent Quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 06/12/19, revealed the MDS was coded to include falls since Admission/Entry or Prior Omnibus Budget	F 657	Practical Nurse (LPN), Minimum Data Set (MDS)/Admissions Coordinator, Environmental Supervisor, Unit One Manager/ Registered Nurse (RN), Unit Two Manager/Registered Nurse (RN) Dietary Manager, Minimum Data Set (MDS) Coordinator, Medical Records Clerk/Licensed Practical Nurse (LPN), Therapy Supervisor, reviewed the policy and procedure for Care Plans, Comprehensive Person-Centered, Falls-Clinical Protocol and Assessing Falls and Their Causes with no recommended changes to the policy at this time. 3. Care plans for residents with falls were revised to reflect accurate needs of each resident on 8/29/2019 by Unit Managers. On 8/28/2019, the Director of Nursing (DON) in-serviced all Nursing staff (Registered Nurses and Licensed Practical Nurses) on the importance of the Resident's care plan being Resident specific and reflecting their individual needs, comprehensive care plans, falls clinical protocol, assessing falls and their causes, and interventions required for each incident. The facility Director of Nursing (DON) or Medical Records Clerk/ Licensed Practical Nurse (LPN), will monitor all incidents for appropriate interventions for prevention and follow through care planning. These will be logged daily and followed weekly at High Risk meeting to ensure appropriate interventions are in place and documented on the Incident Intervention Monitoring Log for three (3) months for compliance beginning on 8/26/19. These will be logged and followed weekly at High		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2019
NAME OF PROVIDER OR SUPPLIER FOREST HILL NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 657	Continued From page 24 Reconciliation Act (OBRA) Assessment or scheduled Prospective Payment System (PPS) Assessment and coded to include injury except major. Review of the Annual MDS, with an ARD of 03/14/19, revealed the resident was coded for falls since admission/reentry/prior assessment: any falls-yes. Falls since admission/reentry/prior assessment: no injury two or more falls was coded. Falls since admission/reentry/prior assessment: major injury was coded one. On 07/31/19 at 3:58 PM, an interview with Licensed Practical Nurse (LPN) #3/MDS Coordinator, revealed the Care Plan should be updated with each MDS assessment. She stated the Comprehensive Care Plan should be updated and an intervention should be put in place as soon as a resident has a fall. She stated Resident #37's Comprehensive Care Plan had not been updated to include interventions for falls that had occurred from January 2019 through April 2019. LPN #3 stated Resident #37 needed to be in the high traffic area at all times so he could be monitored at all times. LPN #3 also stated the Comprehensive Care Plan did not reflect the resident's current status. She stated the resident was not able to ambulate, but can pivot with assistance with transfers. She stated as the MDS Coordinator she makes sure that interventions are put in place after a fall for the resident, but the Director of Nurses (DON) is primarily responsible for putting interventions in place after a resident fall. On 07/31/19 at 4:24 PM, an interview with the DON, revealed the Staffing Coordinator had been doing staff in-services. The DON stated, "to tell you the truth", These falls should be discussed in the morning and weekly hi risk Quality Assurance	F 657	Risk meeting to ensure appropriate interventions are in place. 4. Findings will be brought to Quality Assurance (QA) Committee meeting quarterly for compliance and recommendations.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2019
NAME OF PROVIDER OR SUPPLIER FOREST HILL NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 657	Continued From page 25 Performance Improvement (QAPI) meetings. She stated when the Department Heads are not here, the primary nurse caring for the resident should put an intervention in place after each fall. The DON also stated the current Comprehensive Care Plan does not reflect Resident #37's current status. She also stated the Comprehensive Care Plan does not include interventions for the falls that occurred on 01/27/19, 02/14/19, 02/26/19, 02/27/19, 03/04/19, 03/09/19, 03/16/19 03/18/19, 03/29/19, and 04/05/19. A review of the Face Sheet revealed the facility admitted Resident #37, on 03/28/18, with a diagnosis of Congested Heart Failure (CHF). Review of the most recent Quarterly MDS assessment, with an ARD of 06/12/19, revealed, Resident #37 had a Brief Interview of Mental Status (BIMS) score of 5, which indicated a severe cognitive impairment.	F 657			
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, facility policy review, and review of the Mississippi Nurse Aide Written (or oral) Examination & Skills Evaluation Candidate Handbook, review of the Mosby's Pocket Guide to Nursing Skills & Procedures, Perry.Potter Eighth Edition, Review of the Administrative Code For The Mississippi Board of Nursing, Title 30: Professions and	F 658	F658 1. Certified Nursing Assistant (CNA) #4 no longer employed at the Facility. Resident #123 was assessment by the Director of Nursing (DON) on 8/05/19 for complication from enteral feeding being turned off.		9/3/19

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2019
NAME OF PROVIDER OR SUPPLIER FOREST HILL NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 658	Continued From page 26 Occupations Parts 2801-2900, the facility failed to ensure the Certified Nursing Assistant (CNA) provided resident care within the scope of the CNA's skills for one (1) of two (2) catheter care observations. Resident #123. Findings Include: Review of the Mississippi Nursing Practice Law, with an effective date of July 1, 2010, revealed on pages three and four (3 & 4) of 26: 73-15-5 Definitions. (2) The practice of nursing by a registered nurse means the performance for compensation of services which requires substantial knowledge of biological, physical, behavioral, psychological, and sociological sciences, and of nursing theory as the basis for assessment, diagnosis, planning intervention, and evaluation in the promotion, maintenance of health; management of individual's responses, to illness, injury or infirmity; the restoration of optimum function; or the achievement of a dignified death. Nursing practice includes, but is not limited to, administration, teaching, counseling, delegation, and supervision of nursing, and execution of the medical regimen, including the administration of medications, and treatments prescribed by any licensed or legally authorized physician, or dentist. (5) The practice of nursing by a licensed practical nurse means the performance for compensation of services requiring basic knowledge of the biological, physical, behavioral, psychological, and sociological sciences, and of nursing procedures which do not require the substantial skill, judgement, and knowledge required of a registered nurse. These services are performed under the direction of a registered nurse, or a licensed physician, or licensed dentist, and utilize standardized procedures in the observation, and	F 658	2. Four (4) resident receiving enteral feedings, via continuous or gravity feeding, have the potential to be affected by this deficient practice. The Director of Nursing (DON) assessed all residents receiving enteral feeding, via continuous or gravity, with zero Residents noted with weight loss, on 8/05/2019 with zero (0) Residents noted to have weight loss. On 8/29/2019, the Quality Assurance (QA) Committee, consisting of, Administrator, Medical Director, Director of Nursing/Infection Control Preventionist (DON), Social Services Director, Wound Care/Licensed Practical Nurse (LPN), Minimum Data Set (MDS)/Admissions Coordinator, Environmental Supervisor, Unit One Manager/ Registered Nurse (RN), Unit Two Manager/Registered Nurse (RN), Dietary Manager, Minimum Data Set (MDS) Coordinator, Medical Records Clerk/Licensed Practical Nurse (LPN), Therapy Supervisor, reviewed the policy and procedure for Enteral Nutrition with no recommended changes to the policy at this time. 3. On 08/01/2019, the Staff Development Nurse in-serviced all Certified Nursing Assistants (CNA) on enteral feedings and reiterated that pumps cannot be turned on and/or off per Certified Nursing Assistants (CNA) because it is not within their scope of practice. The Unit Manager on each unit will observe/monitor Resident care on two (2) Residents per unit per week for six (6) weeks for compliance with Certified Nursing Assistant (CNA) scope of practice regarding enteral feeding and document		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2019
NAME OF PROVIDER OR SUPPLIER FOREST HILL NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 658	Continued From page 27 care of the ill, injured, and infirm; in the maintenance of health; in action to safeguard life and health; and in the administration of medications, and treatments prescribed by any licensed physician, or licensed dentist authorized by state law to prescribe. Review of the Mississippi Nurse Aide Written (or oral) Examination & Skills Evaluation Candidate Handbook, dated July 2018, revealed the Skills Listing from page 25 to page 39 did not include the operation of feeding pumps. Review of the Administrative Code For The Mississippi Board of Nursing, Title 30: Professions and Occupations Parts 2801-2900, dated March 16, 2012, pages 13 and 14, revealed: Rule 1.2 Unprofessional Conduct Defined. Unprofessional conduct shall include but not be limited to the following: J. Permitting, aiding, or abetting an unlicensed person to perform activities requiring a license. L. Inappropriately delegating tasks to individuals licensed or unlicensed when the person lacks educational preparedness, experience, credentials, competence, or physical, or emotional ability to complete the task. Review of the Mosby's Pocket Guide to Nursing Skills & Procedures, Perry.Potter Eighth Edition, Copy Right 2015 revealed: (1) Page 168 Skill 25: Enteral Nutrition via a Nasoenteric Feeding Tube: Delegation Considerations: The skill of administration of nasoenteric tube feedings can be delegated to nursing assistive personnel (NAP). However a registered nurse (RN) or licensed practical nurse (LPN) must first verify tube placement, and patency. The nurse directs the NAP to: Not adjust feeding rate, infuse the feeding as ordered. (2) Page 555 Skill 76:	F 658	on the Unit Manager- Resident Care (Enteral Feeding) Log. Any concerns will be corrected immediately and the Director of Nursing (DON) will be notified. 4. Findings will be logged and followed weekly at High Risk meeting to ensure appropriate interventions are in place. Findings will be brought to Quality Assurance (QA) Committee meeting monthly for compliance and recommendations.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2019
NAME OF PROVIDER OR SUPPLIER FOREST HILL NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 658	Continued From page 28 Review of the facility's policy titled, "Gastric Tube Feeding via Continuous Pump, revised March 2018, revealed the purpose of this procedure is to provide nourishment to the resident who is unable to obtain nourishment orally. Further review of the policy revealed no staff identification as who should or should not operate the feeding pump. Record Review of Resident #123's August 2019 Physician's Orders revealed an order, dated 07/17/19 for Jevity 1.5 cal at 40 milliliters per hour (ml/hr) via feeding continuous pump via Percutaneous Endoscopic Gastrostomy (PEG) tube due to Aphasia following Cerebrovascular Disease. An observation, on 08/01/19 at 10:01 AM, revealed Certified Nursing Assistant (CNA) #4 provided Resident #123's catheter care. CNA #4 turned the feeding pump off. Adjusted the bed. CNA #4 cleaned from front to back, secured base of the catheter while providing catheter care. CNA #4 turned the pump on after the care was completed. During an Interview, on 07/31/19 at 4:29 PM, CNA #4 said she normally turned the pump off prior to providing care because leaving the pump on will cause the resident to aspirate. CNA #4 said maybe she shouldn't have turned the pump off. CNA #4 said maybe she should have put it on hold. Record Review of the Care Plan revealed the Problem/Need, dated 07/17/19, for the potential for dehydration secondary to receiving all of his fluids/nutritional needs per the PEG tube. The role for the Problem was an N for Nursing.	F 658			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2019
NAME OF PROVIDER OR SUPPLIER FOREST HILL NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 658	Continued From page 29 During an interview, on 07/31/19 at 4:40 PM, the Director of Nursing (DON) revealed CNA #4 failed to follow the facility policy. The CNAs are trained to ask the nurse to turn the feeding pumps off prior to performing catheter care. A review of the Face Sheet revealed the facility admitted Resident #123, on 07/17/2019, with diagnoses which included Aphasia following other Cerebrovascular Disease, History of Urinary Tract Infection, Stage 4 Pressure Ulcer, and Gastrostomy. A review of Resident #123's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/23/2019, revealed Resident #123 had a Brief Interview for Mental Status (BIMS) score of 99 which indicated the facility was not able to complete the interview. Resident #123 was coded a 3 for Cognitive Skills for daily decision making, which indicated the resident rarely or never made decisions.	F 658			
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and	F 755		9/3/19	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2019
NAME OF PROVIDER OR SUPPLIER FOREST HILL NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 755	Continued From page 30 biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, record review, and facility policy review, the facility failed to ensure Resident #28's medications were available for one of three (1 of 3) residents reviewed for medication administration. Findings include: A review of a document provided by the Director of Nursing (DON)/Interim Infection Control Nurse, 07/31/19 revealed, "We do not have a specific policy for ordering medications related to cycle refills". An interview, on 07/30/19 at 9:36 AM, revealed LPN #1 stated, "the resident is out of Lyrica. I'm not sure how long he has been out of the medication. I don't have the Lyrica to give him this morning. I never saw where Lyrica (An	F 755	F755 1. On 07/30/2019, Resident # 28 received Lyrica 75 milligrams (mg) by mouth (po) per Medical Doctor (MD) order. An immediate in-service for nurses began on 07/30/2019 regarding medication ordering and receiving medications per Director of Nursing (DON). 2. All residents receiving medications have the potential to be affected by this deficient practice. On 8/29/2019, the Quality Assurance (QA) Committee, consisting of, Administrator, Medical Director, Director Of Nursing/Infection Control Preventionist (DON), Social Services Director, Wound Care/Licensed Practical Nurse (LPN), Minimum Date Set		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2019
NAME OF PROVIDER OR SUPPLIER FOREST HILL NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 755	Continued From page 31 Anticonvulsant and also used to treat neuropathy/nerve damage pain) was in the Pixis (after hour medication dispenser)". An observation, on 07/30/19 at 10:09 AM, revealed Licensed Practical Nurse (LPN) #1 entered Resident #26's room to administer his medications. Upon entering the room Resident #26 stated he had not had his Lyrica since 07/29/19. Resident #26 said they got his pain pill out of the Pixis last night. LPN #1 stated, "I worked last Friday and we sent the request to the Nurse Practitioner (NP) for a hard script for his Lyrica but we don't have it today. I called the pharmacy today and they told me they didn't have the script. I told my nurse supervisor (Registered Nurse #1) and she called them to. They told her they didn't have a hard prescription either. I don't have Lyrica in the after hour medication dispenser (Pixis) to give him this morning". An interview, on 07/30/19 10:50 AM, with RN #1 revealed, she called the pharmacy this morning and they said they were waiting on the physician's signature for the Lyrica. Pharmacy said they got the request yesterday but could not fill it because they didn't have a signed prescription for it. They were waiting on the physician's signature. The Lyrica is not at the facility today that I know of. An interview, on 7/30/19 at 10:55 AM, with LPN #1 revealed, she did not have any Lyrica to give him this morning. LPN #1 said she called the pharmacy this morning and they told her they didn't have an order for the Lyrica, and that they needed a prescription signed before they could send the medication. Record review of the July 2019 Electronic	F 755	(MDS)/Admissions Coordinator, Environmental Supervisor, Unit One Manager/Registered Nurse (RN), Unit Two Manager/Registered Nurse (RN), Dietary Manager, Minimum Data Set (MDS) Coordinator, Environmental Supervisor, Medical Records Clerk/Licensed Practical Nurse (LPN), Therapy Supervisor, reviewed the policy and procedure for Accepting Delivery of Medications and Medication Orders and Receipt Record with no recommended changes to the policy at this time. 3. All nurses in-serviced on 7/30/2019 regarding ordering and receiving medication per Director of Nursing (DON) and completed on 8/29/2019. No nurse will be allowed to work until in-service is completed. Medication order binders have been placed at each nursing station and Unit Managers will audit these binders every day Monday through Friday to ensure medications are ordered timely. Each Unit Manager will document audits on the medication order log at each station binder for three (3) months. 4. Any concern will be addressed immediately and the Director of Nursing (DON) will be notified. Findings will be brought to Quality Assurance (QA) Committee meeting quarterly for compliance and recommendations.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2019
NAME OF PROVIDER OR SUPPLIER FOREST HILL NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 755	Continued From page 32 Medication Administration Record (EMAR) for Resident #26, revealed Lyrica was signed as not being administered on 07/29/19 at 5 PM and 07/30/19 at 9 AM. Record review of the July 2019 Physician's Orders, revealed an order, dated 05/23/19, for Lyrica 75 milligrams (mg), one (1) capsule by mouth twice a day. Further review revealed an order, dated 05/23/19 for Norco 10-325 tablet, give one by mouth every 12 hours as needed for breakthrough pain. Further review also revealed an order dated, 05/28/19, for Fentanyl 12 microgram per hour (mcg/hr) related to breakthrough pain. (The July 2019 EMAR documented the last Fentanyl Patch was administered on 07/27/19.) There was also an order, dated 05/23/19, for Tylenol Extra Strength 500 milligram (mg) caplet by mouth every six hours as needed for pain, for pain scale of one to five (1-5). Record review of the Narcotic Sign-Out Sheet for Resident #26's Lyrica revealed the last dose of medication was signed out on 07/29/19 at 9 AM. An observation, on 07/30/19 at 11:40 AM, revealed while the surveyor was sitting at the nurse's station a CNA came and told RN #1 that Resident #26 was in his room acting out and throwing things. On entrance to the room, Resident #26 was lying in bed. The Director of Nursing (DON) was at Resident #26's bedside. Resident #26 stated he had not received his Lyrica since yesterday morning, that he had not received his Lyrica in two days. An interview, on 07/30/19 at 2:55 PM, with LPN #1, revealed she should have called the Nurse	F 755			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2019
NAME OF PROVIDER OR SUPPLIER FOREST HILL NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 755	Continued From page 33 Practitioner (NP) or the physician to go ahead and send the hard prescription (Rx) for Resident #26 to the pharmacy when she saw he was out of medication. Record review of the Delivery Manifest revealed Resident #26's Lyrica was delivered to the facility on 07/30/19, and checked in on the 3-11 shift. An interview, on 07/30/19 at 11:23 AM, with RN #1 revealed the facility had a back-up pharmacy She wanted to say it is (Name of Pharmacy), but she was not sure why they were not used. RN #1 said she still didn't know if the resident's Lyrica was at the facility at this time. An interview, on 07/30/19 at 11:24 AM, with LPN #1 revealed, "I worked last Friday, and I realized he was out of the Lyrica, so I faxed a request to the pharmacy for the medication". An interview, on 07/30/19 at 11:42 AM, with the Director of Nursing (DON) revealed, Resident #26 missed last night's Lyrica. The DON stated they have a back-up pharmacy, it is (Name of Pharmacy. If the nurses don't have the medication then they should call the physician to get a hold order on the medication, or to get a replacement medication. Evidentially they didn't call the doctor or the Nurse Practitioner (NP). They should have called one or the other when they first saw that Resident #26 was running out of his Lyrica. If they don't have the medication they should call the physician or the NP, and ask for a prescription or at least for something to replace the medication until the medication can be ordered and come from the pharmacy. They should get an order to hold the medication if it's not here. The DON said she did not know that	F 755			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2019
NAME OF PROVIDER OR SUPPLIER FOREST HILL NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 755	Continued From page 34 Resident #26's medication was not here until about 15 minutes ago when RN #1 told me. An interview, on 07/30/19 at 11:53 AM, revealed the facility's Pharmacist stated, "the facility doesn't have Lyrica in the Pixis for them to get out. We did not receive an order over the weekend for Resident #26's Lyrica. We have not filled the Lyrica since 06/26/19. They could send a request all day, but without a signed hard script from the physician, we would not have sent it. If the medication was not a schedule II the physician could have called it in to (Name of Pharmacy), and someone would have had to go pick it up from them. Lyrica is not a schedule II so that should have been called to (Name of Pharmacy). We have nothing on file for the Lyrica to be refilled. I don't understand. They have a card with the medication on it, and they can see before they are running out of a narcotic. But they still let it run out. They are not ordering medications accordingly, or they would not run out of the medication. This issue has been a problem for the facility as well as other facilities". An interview, on 07/30/19 at 12:15 PM, with RN #1 revealed, she just took an order from the Nurse Practitioner (NP) and wrote the order at 12:07 PM to hold the Lyrica until it could get here. We have obtained a new script for Resident #26's Lyrica, and the NP sent them to the pharmacy, and I've resent them to the pharmacy also. An interview, on 07/31/19 at 1:35 PM with the Nurse Practitioner revealed, it is not recommended to stop Lyrica abruptly because you can have withdrawal symptoms. The NP stated she did not think Resident #26 would have withdrawal symptoms just missing a couple	F 755			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2019
NAME OF PROVIDER OR SUPPLIER FOREST HILL NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 755	Continued From page 35 doses, but it was hard to say. The NP stated her understanding was that apparently Resident #26 ran out of medications this weekend. The NP stated she gave a hold order until the medication could arrive, and she sent a new script over to the pharmacy yesterday. An interview, on 08/01/19 at 8:10 AM, with the DON revealed, "we do have a problem with the nurses not ordering medications in a timely manner. The nurses just need some education on ordering narcotics. The nurses may just fax a request over to the pharmacy for a narcotic and not realize they need an order from the physician, and the physician needs to physically sign the order. The nurses need to follow up when ordering medications to make sure they arrive to the facility. It is every nurse's responsibility to order medication". An interview, on 08/01/19 at 5:31 PM, revealed the Administrator stated, "The nurses should have immediately called the Medical Director and got instructions as what to do when the medication is out. Whatever the MD says to do is what we need to do. Doing nothing is not the right thing to do. We have to be diligent in keeping enough medications at the facility for the residents".	F 755			
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable	F 880		9/3/19	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2019
NAME OF PROVIDER OR SUPPLIER FOREST HILL NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 880	Continued From page 36 diseases and infections. §483.80(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: §483.80(a)(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 arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(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	F 880			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2019
NAME OF PROVIDER OR SUPPLIER FOREST HILL NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 880	Continued From page 37 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 by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(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 observations, staff interviews, record review, and facility policy review, the facility failed to administer medications in a manner to prevent possible spread of infection for two (2) of five (5) resident medication pass observations for Residents #56 and Unsampled Resident A, provide wound care in a manner to prevent the possible spread of infection for two (2) of three (3) resident wound care observations, Residents #26 and #35, provide gastric tube site dressing change in a manner to prevent the possible spread of infection for one (1) of two (2) resident gastric tube site dressing change observations, Resident #27, and failed to provide catheter care in a manner to prevent the possible spread of infection for one (1) of two (2) resident catheter care observations, Resident #35.	F 880	F880 1. On 8/05/2019, Resident # 56 and Unsampled Resident A eyes were assessed per Director of Nursing (DON) for signs and symptoms of infection with no new issues noted. On 8/05/2019, Resident # 26 and Resident # 35 wounds were assessed per Unit Manager for change in condition or signs of wound infection with no new issues noted. On 8/20/2019, the Percutaneous Endoscopic Gastrostomy (PEG) site for Resident #27 was assessed per Staff Development Coordinator for sign and symptoms of infection with none noted. On 8/19/2019, Resident #35 was assessed per Medical Records Clerk/Licensed Practical Nurse		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2019
NAME OF PROVIDER OR SUPPLIER FOREST HILL NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 880	Continued From page 38 Findings include: A review of the facility's policy titled, "Infection Control Guidelines for All Nursing Procedures", dated February 2019, revealed: "The purpose of the guidelines is for general infection control while caring for residents. The general guidelines include the use of Standard Precautions in the care of all residents in all situations regardless of suspected or confirmed presence of infectious disease. Standard Precautions apply to blood, body fluids, secretions, and excretions regardless of whether or not they contain visible blood, non-intact skin, and/or mucous membranes. Employees must wash their hands using antimicrobial or non-antimicrobial soap and water under the following conditions: before and after direct contact with residents; after contact with blood, body fluids, secretions, mucous membranes, or non-intact skin, and after removing gloves. In most situations, the preferred method of hand hygiene is with an alcohol based hand rub if the hands are not visibly soiled. Alcohol based hand rub should be used before handling clean or soiled dressings, gauze pads, etc.; before moving from a contaminated body site to a clean body site during resident care; after contact with a residents intact skin; after handling used dressings, contaminated equipment, etc.; after contact with objects (medical equipment) in the immediate vicinity of the resident and after removing gloves. A review of facility's policy titled, "Catheter Care, Urinary" dated September 2014, revealed, "The purpose of this policy is to prevent catheter-associated urinary tract infections. The urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the	F 880	for signs or symptoms of urinary complications with no issues noted. 2. All Residents have the potential to be affected by this deficient practice. On 8/29/2019, the Quality Assurance (QA) Committee, consisting of Administrator, Medical Director, Director of Nursing/Infection Control Preventionist (DON), Social Services Director, Wound Care/Licensed Practical Nurse (LPN), Minimum Data Set (MDS)/Admissions Coordinator, Environmental Supervisor, Unit One Manager/Registered Nurse (RN), Unit Two Manager/Registered Nurse (RN), Dietary Manager, Minimum Data Set (MDS) Coordinator, Environmental Supervisor, Medical Records Clerk/Licensed Practical Nurse (LPN), Therapy Supervisor, reviewed the policy and procedure for Gastrostomy/Jejunostomy Site Care, Infection Control Guidelines, Hand Washing/Hand Hygiene, Policies and Practices- Infection Control, Standard Precautions, Instillation Eye Drops, Wound Care and Catheter Care- Urinary with no recommended changes to the policy at this time. 3. On 8/02/2019, Licensed Practical Nurse (LPN) #4 was in-serviced on proper infection control, eye medication administration and artificial nails by Director of Nursing (DON). On 8/29/2019, Licensed Practical Nurse (LPN) #1 was in-serviced on hand hygiene, infection control, eye medication administration, artificial nails and medication administration of opening capsules by Director of Nursing (DON). On 8/06/2019,		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2019
NAME OF PROVIDER OR SUPPLIER FOREST HILL NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 880	Continued From page 39 urine in the tubing and drainage bag from flowing back into the urinary bladder". A review of the facility's policy titled, "Gastrostomy/Jejunostomy Site Care", dated March 2018, revealed: The Purpose of this procedure is to promote cleanliness and to protect the gastrostomy or jejunostomy site from irritation, breakdown and infection. Steps in the procedure included: 1. Place the equipment on the bedside stand or overbed table on a clean barrier. Arrange the supplies so they can be easily reached. 2. Wash hands and dry thoroughly. 3. Wear clean gloves. A review of the facility's policy titled, "This Facility Considers Hand Hygiene The Primary Means To Prevent The Spread Of Infection", revealed: Policy Interpretation and Implementation: 7. Use an alcohol-based hand rub containing at least 62%; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: B. Before and after direct contact with residents, F. Before donning sterile gloves, K. After handling used dressings, contaminated equipment, etc., M. After removing gloves. Unsampled Resident A On 7/31/19 at 8:45 AM, an observation revealed Licensed Practical Nurse (LPN) #4 used Alcohol Based Hand Gel (ABHG), reached in her left uniform pocket, pulled out a pair of gloves, and applied them prior to putting the Artificial Tears in Unsampled Resident A's left eye. LPN #4 opened the Artificial Tears, placed the top of the eye drop bottle on the resident's over bed table that had not been cleaned, and did not have a barrier. While applying the eye drops, LPN #4	F 880	Licensed Practical Nurse (LPN) #2 was in-serviced on proper infection control, wound care, hand hygiene and potential for urinary tract complications related to height of the catheter drainage bag related to location of the bladder by Director of Nursing (DON). On 8/02/2019, Certified Nursing Assistant (CNA) #3 was in-serviced on proper infection control, hand hygiene, and potential for urinary tract complications related to height of the catheter related in location of the bladder by the Director of Nursing (DON). On 8/06/2019, Registered Nursing (RN) #2 was in-serviced on proper infection control, hand hygiene and PEG site care. On 8/13/2019 check off for competency was initiated per Charge Nurses with all Registered Nurses (RN) and Licensed Practical Nurses (LPN) on Medication Administration, Eye Medication Administration, Infection Control, PEG site Care, Hand Hygiene and Wound Care. No Registered Nurses (RN) or Licensed Practical Nurses (LPN) will be allowed to work until completion of competency checks. On 8/09/19, competency checks initiated per Charge Nurses for all Certified Nursing Assistants (CNA) on Infection Control, Peri/Catheter care and hand hygiene. No Certified Nursing Assistants (CNA) will be allowed to work until competency checks have been completed. Unit Manager Three (3) for each unit will observe five (5) eye medication administrations per unit per week for six (6) weeks begin on 8/03/19 for compliance and document results on Eye Drop/Medication Audit. Any concerns		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2019
NAME OF PROVIDER OR SUPPLIER FOREST HILL NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 880	Continued From page 40 touched the tip of the Artificial Tears eye drop bottle to the resident's right eyelid. On 7/31/19 at 2:10 PM, an interview with Licensed Practical Nurse #4, revealed she would turn the light on the next time she gives eye drops to be sure she could see better. LPN #4 stated she would use the gloves that are hanging on the wall in the resident's room the next time she needed to use gloves. She stated it is an infection control problem to take gloves from her pocket and use them, because she never knows what is in her pocket. LPN #4 stated touching the resident's eyelid with the tip of the eye drop bottle is an infection control issue also because the bottle should not touch the resident's eyelid. She also stated, she should have wiped the over-bed table or placed a barrier on the table before sitting the Natural Tears eye drop bottle top on the over-bed table. On 8/1/19 at 4:15 PM, an interview with the Director of Nurses (DON) revealed, LPN #4 should have had a clean barrier on the resident's (referring to Unsampled Resident A) over-bed table and should have wiped the table off. She stated LPN #4 should not have had any gloves or anything else in her pocket. The DON also stated the resident's Artificial Tears eye drops bottle tip should not have touched the resident's eyelid because that is an infection control issue. Review of Unsampled Resident A's Physician's Orders, revealed an order dated 6/20/17 for Artificial Tears, one drop to both eyes twice a day for Dry Eye Syndrome of Bilateral Lacrimal Glands. A review of the Face Sheet revealed the facility	F 880	will be corrected immediately and the Director of Nursing (DON) will be notified. Beginning on 8/23/19, Unit Manager Three (3) will observe catheter care on three (3) residents per unit per week for six (6) weeks for compliance and document on the Catheter Care Audit log. Beginning on 8/16/19, the Unit Managers or Director of Nursing (DON) will observe five (5) wound care procedures per week for six (6) weeks for compliance and document on the Wound Care Audit log. Any issues will be addressed immediately and Director of Nursing (DON) will be notified. Beginning on 8/26/19, Unit Manager Three (3) will observe PEG Care to site on three (3) residents per Unit per week for six (6) weeks for compliance and document on the Peg Care Audit log. 4. Any issues will be addressed immediately and the Director of Nursing (DON) will be notified. The Director of Nursing (DON) will report any issues to quarterly Quality Assurance (QA) meeting for review and recommendations.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2019
NAME OF PROVIDER OR SUPPLIER FOREST HILL NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 880	Continued From page 41 admitted Unsampled Resident A, on 08/21/19, with the included diagnoses of Cataract, Dry Eye Syndrome of Bilateral Lacrimal Glands, and Glaucoma. Resident #56 An observation, on 07/30/19 at 10:25 AM, revealed Licensed Practical Nurse (LPN) #1 prepared Resident #56's medications. Resident #56 was sitting in his wheelchair by the medication cart awaiting his medications. LPN #1 did not wash her hands before she began to pour up the medications. LPN #1 pulled the residents Omeprazole, Cymbalta and Neurontin capsules from their respective cards, and put them into a medication cup. LPN #1 picked up the Omeprazole capsule with her ungloved hands, pulled it apart and put the contents into another med cup. LPN #1 then took the Cymbalta capsule out of the first medication cup with her ungloved hands, and tried to pull the capsule apart. The capsule would not come apart, so LPN #1 used her fingernails, which were acrylic nails, to help prize the capsule apart. LPN #1 put the contents of the capsule into the medication cup with the Omeprazole. LPN #1 removed the Neurontin capsule from the first medication cup with her ungloved hands, and again took her fingernail and prized the capsule open and added this to the other medications in the second medication cup. LPN #1 mixed the medications with applesauce and administered them to the Resident #56. LPN #1 then gloved without performing hand hygiene, picked up Resident #56's Imprimis eye drops and dropped them onto the eye lid of Resident #56's left closed eye. LPN #1 sat the drops on top of her computer on the medication cart without a barrier, and then took	F 880			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2019
NAME OF PROVIDER OR SUPPLIER FOREST HILL NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 880	Continued From page 42 her hands and pulled Resident #56's left eye open. LPN #1 stated that the resident had surgery on his left eye a few days ago. LPN #1 did this twice before she got the drops into Resident #56's left eye, each time sitting the drops on top of the computer on her cart without a barrier. LPN #1 took her right gloved forefinger and rubbed the drops upward into Resident #56's left eye. LPN #1 kept the same gloves on and picked up Resident #56's Durezol eye drops and attempted to drop them into his left eye. The drop fell onto the outside of Resident #56's left eye. LPN #1 never noticed drops were not in Resident #56's eye. LPN #1 removed her gloves, and without washing her hands she re-gloved and picked up the third eye drop, Combigen, and placed the drop in Resident #56's left eye. The drop fell onto Resident #56's eye lid, and LPN #1 took her right forefinger and pushed the drop into his eye. When LPN #1 was asked about the Durezol drop, not getting into Resident #56's eye, LPN #1 stated "Oh I thought it went in the eye. I'll put them in again". LPN #1 obtained the Durezol drops from the top of the computer on the medication cart, where she had set them without a barrier, and reapplied the drops in Resident #56's left eye. LPN #1 didn't wash her hands before preparing medications or after removing gloves, or before re-gloving. An interview, on 07/30/19 at 2:55 PM, revealed LPN #1 stated she remembered opening the three (3) medications with her bare hands, and using her fingernail to help open the capsules. LPN #1 said she should have washed her hands and wore gloves. LPN #1 said it was an infection control issue. LPN #1 said she put gloves on and tried to put the Imprimis drops into Resident #56's left eye, and he kept closing his eye. LPN #1 said	F 880			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2019
NAME OF PROVIDER OR SUPPLIER FOREST HILL NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 880	Continued From page 43 she set the drops on top of her computer and didn't have a barrier. LPN #1 said she picked up the drops and put the drops onto his eyelid, and then set the eye drops on top of her computer with no barrier. LPN #1 said she took her hands, and tried to open his eye for the drops to go in. LPN #1 said she took her gloved forefinger and wiped the drops into the edge of Resident #56's eye. LPN #1 said she didn't change her gloves, and then she picked up the Durezol eye drops and put them into his left eye. LPN #1 said she thought the drops went into the eye, but after the surveyor brought it to her attention that she saw them not go in, she (LPN #1) did put those drops into his eye again. LPN #1 said she set the drops on top of her computer and didn't use a barrier. LPN #1 said she took her gloves off and reapplied gloves, but did not wash her hands before she started or when she removed her gloves. LPN #1 stated she did take her finger and kind of rake the drops into Resident #56's left eye. LPN #1 stated she should have not used her finger to do that. LPN #1 stated not washing her hands, and taking her finger to put the drops into the eye could cause an infection, and this was an infection control issue. LPN #1 stated she didn't change gloves between applying the first and second drops, and she should have used a barrier to sit the drops on instead of sitting them on the computer on the cart. An interview, on 08/01/19 at 8:10 AM, with the Director of Nursing (DON)/Interim Infection Control Nurse revealed, "LPN #1 opening the medication with her ungloved hands and using her fingernails to open the pills is definitely an infection control issue. The DON stated LPN #1 taking her gloved finger and putting the drops up into Resident #56's eye is an infection control	F 880			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2019
NAME OF PROVIDER OR SUPPLIER FOREST HILL NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 880	Continued From page 44 issue, and changing her gloves between eye drops is an infection control issue. The DON stated LPN #1 should have changed her gloves. LPN #1 not washing her hands between glove change is an infection control issue. The DON stated LPN #1 setting the eye drops on top of her computer without a barrier is an infection control issue". Resident #26 An observation on 08/01/19 at 8:32 AM, revealed Licensed Practical Nurse (LPN) #2 entered Resident #26's room to provide wound care. Resident #26 had a Stage IV Pressure Ulcer to the right and left Ischium and Sacrum. Resident #26 was lying with the bed in a flat position, on his right side facing the wall. LPN #2 exited the room, and returned to the wound care cart. LPN #2 re-entered the room, and placed a red biohazard bag in the garbage can. LPN #2 exited the room, but when exiting the room, LPN #2 bumped the bracket on the wall holding a box of gloves and the box of gloves fell on the floor with gloves exposed from the opening of the box. LPN #2 picked the gloves up and put them back in the wall bracket. LPN #2 washed her hands and gloved. LPN #2 put gauze into six (6) plastic drinking cups, and sat the cups on top of the wound care cart with no barrier. LPN #2 poured normal saline into three (3) of the cups and Dakins solution into three (3) of the cups. LPN #2 reached into the drawer of the wound cart and got a container of bleach wipes out and placed several wipes into a plastic drinking cup. LPN #2 sat the cup with the bleach wipes on the wound cart without a barrier. LPN #2 took out two (2) blue disposable pads out of the wound cart and laid them on top of the wound care cart unopened	F 880			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2019
NAME OF PROVIDER OR SUPPLIER FOREST HILL NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 880	Continued From page 45 with no barrier present. LPN #2 removed five (5) 6x6 border gauze and laid them on top of the blue pads. LPN #2 removed her gloves, used hand sanitizer, and then picked up the blue pads, the border gauze, the cup with the bleach wipes in it and entered Resident #26's room. LPN #2 sat the cup containing the bleach wipe, the two blue pads and the border gauze on the over bed table with no barrier. LPN #2 took one blue pad and spread it out on the over bed table as a barrier. LPN #2 left Resident #26's room and went to the wound cart located in the hall, and picked up all six (6) cups without having gloves on or using hand sanitizer. LPN #2 sat all six (6) cups on the blue pad on the over bed table. LPN #2 asked Certified Nurses Aid (CNA) #5, who came into the room, to bring the box of gloves LPN #2 had knocked off the wall earlier to her (LPN #2). CNA #5 went and got the box of gloves that LPN #2 had knocked on the floor, and was picked up and put back on the wall, and placed them in a chair on top of Resident #26's pillow. LPN #2 used hand sanitizer, and also used the gloves from the box of contaminated gloves she had knocked on the floor earlier. LPN #2 opened five (5) border gauzes and placed them on the barrier on the table. LPN #2 reached into her pocket with her gloves on and pulled out a sharpie pen. LPN #2 took one bleach wipe and wiped the sharpie and, then dated and initialed the border gauze dressing. LPN #2 removed her gloves and used hand sanitizer. LPN #2 obtained gloves from the box (contaminated box of gloves) sitting on top of Resident #26's pillow, picked up Resident #26 feet and put them on a blue pad which was already lying on the bed. LPN #2 removed her gloves and used hand sanitizer. LPN #2 gloved and took the catheter drainage bag and laid it on the foot of the bed. LPN #2 removed gloves and	F 880			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2019
NAME OF PROVIDER OR SUPPLIER FOREST HILL NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 880	Continued From page 46 used hand sanitizer. LPN #2 gloved and pulled the over bed table closer to Resident #26. LPN #2 placed the hand sanitizer on the over bed table and not on the barrier. LPN #2 took the second blue barrier and placed it under Resident #26's buttocks. LPN #2 removed the soiled dressing from the Ischium/sacral area and discarded it into the red bag. LPN #2 removed her gloves and used hand sanitizer. LPN #2 gloved and took one (1) gauze out of the drinking cup and wiped the sacral wound from the inner area outwards and then discarded the dressing in the red bag. LPN #2 removed gloved, used hand sanitizer, gloved and removed another gauze with normal saline and wiped the sacral wound again from inner to outward are of the wound. LPN #2 removed gloves and used hand sanitizer. LPN #2 gloved and picked up one of the cups holding the Dakins solution in it, removed a gauze and wiped the sacral wound from inner to outwards and discarded in the red bag. LPN #2 removed gloves and used hand sanitizer. LPN #2 gloved, picked up a cup with Dakins solution in it and took five (5) of the gauze and packed the sacral wound. LPN #2 removed gloves and used hand sanitizer. LPN #2 gloved and applied one (1) 6x6 border gauze to the wound. LPN #2 removed her gloves and used hand sanitizer. LPN #2 gloved and took a cup containing normal saline gauze and wiped the right Ischium wound from the inner area to the outwards area of the wound in a circular motion. LPN #2 discarded soiled gauze in red bag, removed gloves and used hand sanitizer. LPN #2 gloved and used one (1) Dakin solution soaked gauze to wipe around the edges of the wound. LPN #2 used four (4) Dakin solution soaked gauze to pack the wound. LPN #2 removed her gloves. No hand hygiene was performed. LPN #2 gloved and applied a 6x6	F 880			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2019
NAME OF PROVIDER OR SUPPLIER FOREST HILL NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 880	Continued From page 47 border dressing to the wound. LPN #2 removed gloves and used hand sanitizer. LPN #2 gloved and took a cup with normal saline in it, and removed a gauze and wiped the left Ischium from the inner area of the wound to the outer area of the wound in a circular motion. LPN #2 removed her gloves and did not perform hand hygiene. LPN #2 gloved and used one (1) Dakin solution soaked gauze and wiped the wound edges. LPN #2 took three (3) Dakins soaked gauze to pack the wound. LPN #2 removed her gloves and used hand sanitizer. LPN #2 gloved and took a 6x6 border gauze and placed it over the wound and then without changing gloves, applied a 4th 6x6 border gauze over the other three (3) dressings. LPN #2 assisted Resident #26 up in bed with the same gloves on as she applied the last two (2) dressings. LPN #2 gathered supplies, removed gloves and discarded items in red the bag. LPN #2 left room without cleaning her hands and walked to the biohazard room to discard the red bag. LPN #2 returned to the wound care cart and began to push cart down the hall all without performing hand hygiene. LPN #2 stated "I picked the catheter drainage bag up off of Resident #26's bed and hung it on the side of the bed before we left the room. The catheter drainage bag remained on the foot of Resident #26's bed the entire process. On observation, the catheter drainage bag had 250 cc of urine in the bag and the tubing was filled with urine throughout the wound care process. Further observation during Resident #26's wound care revealed the catheter drainage bag was placed on the foot of the bed during the entire wound care. The drainage bag had 250 cubic centimeters (cc) of urine in the bag, and the tubing was filled with urine throughout the wound care.	F 880			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2019
NAME OF PROVIDER OR SUPPLIER FOREST HILL NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 880	Continued From page 48 An interview, on 08/01/19 9:05 AM, with LPN #2, revealed LPN #2 stated she did know you should wash your hands before a procedure, throughout a procedure, when gloves are soiled and after removing gloves. LPN #2 said she bumped the container that the box of gloves was in on the wall with her shoulder and they did fall on the floor. LPN #2 said she did ask CNA #5 to bring her the box of gloves. LPN #2 said she wasn't thinking about the box of gloves being contaminated, and she should have gotten another box. LPN #2 stated she was trained to put the catheter bag on the bed for Resident #26 because of his movements. LPN #2 stated that person doesn't work here anymore. LPN #2 stated she did remember the catheter drainage bag being on the foot of Resident #26's bed during the wound care. LPN #2 said she knew better, and it should have been hanging on the side of the bed that the resident was facing. LPN #2 stated the catheter lying on the bed could cause urine to go back into Residents #26 bladder and cause a Urinary Tract Infection (UTI). It could also damage the bladder if enough urine traveled back into the bladder. LPN #2 said the drainage bag should be below the bladder. An interview, on 08/01/19 8:10 AM, with the Director of Nursing (DON)/Interim Infection Control Nurse, revealed not washing hands between changing gloves is an infection control issue. The DON stated the box of gloves falling on the floor was contaminated, and then LPN #2 using them was an infection control issue. The DON stated LPN #2 should have discarded the box of gloves and obtained another box. The DON stated the catheter drainage bag should not have been placed on the bed at the bladder level. It could have caused a Urinary Tract Infection.	F 880			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2019
NAME OF PROVIDER OR SUPPLIER FOREST HILL NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 880	Continued From page 49 Resident #35 Wound Care An observation, on 07/31/19 at 11:25 AM, revealed Licensed Practical Nurse (LPN) #2 washed her hands at the nurses station, took a paper towel, dried her hands and used the same paper towel to turn the faucet off. LPN #2 entered Resident #35's room to perform wound care to a Healing Stage III Pressure Ulcer to the sacrum. CNA #3 assisted LPN #2 with positioning the resident during the wound care. LPN #2 entered the room, and performed hand hygiene with sanitizer by the door. LPN #2 gloved and entered Resident #35's side of the room where the privacy curtain was pulled. Upon entry, there were two (2) overbed tables set up on Resident #35's side of the room; one with wound care supplies and the other with catheter care supplies. Neither tray was covered. Resident #35's catheter drainage bag was lying on top of the bed at Resident #35's feet. The catheter had 200 cc of urine in the bag, and the catheter tubing was full of urine which had some sediment in it. LPN #2 gloved and moved the over bed table that the catheter care supplies were set up on, from Resident #35's side of the room to the roommate's side of the room (just on the other side of the privacy curtain). The over bed table with the supplies for catheter care was left open to air. LPN #2 removed her gloves and used hand sanitizer. There was no sink in Resident #35's room. LPN #35 gloved and laid a disposable pad under Resident #35's buttocks. LPN #2 removed the soiled dressing from the sacrum and discarded it into a red biohazard bag. LPN #2	F 880			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2019
NAME OF PROVIDER OR SUPPLIER FOREST HILL NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 880	Continued From page 50 removed her gloves and used hand sanitizer. LPN #2 gloved, then reached and picked up a drinking cup containing gauze and normal saline that was sitting on her barrier on the over bed table. LPN #2 took a piece of gauze and wiped the wound in a circular motion from inside of the wound area to outside of wound. LPN #2 disposed of the gauze in the red biohazard bag. LPN #2 removed her gloves and used hand sanitizer. LPN #2 applied gloves and took the second piece of gauze and wiped the wound in a circular motion, inside to outside, and discarded soiled gauze. LPN #2 removed her gloves and used hand sanitizer. LPN #2 gloved and opened the Zerfoam dressing and laid it on the barrier on table. LPN #2 picked up the medication cup with the collagen in it and applied the collagen to the top of the Zerfoam dressing. LPN #2 kept the same gloves on and applied the Zerfoam dressing to the wound. LPN #2 removed her gloves and used hand sanitizer. LPN #2 gloved and applied a foam dressing over the Zerfoam dressing. LPN #2 removed her gloves and used hand sanitizer. LPN #2 realized that Resident #35 had a re-opened area to his right Ischium. LPN #2 stated that she had to leave the room to go get supplies for the new area. LPN #2 gathered her barrier and trash and threw it away in the red biohazard bag and left the room. Certified Nursing Assistant (CNA) #3 reached and pulled the over bed table that she had set up for catheter care onto Resident #35's side of the room. CNA #3 used hand sanitizer, gloved and waited for LPN #2 to return to finish wound care so she could perform catheter care. LPN #2 entered Resident #35's room with the supplies for the new wound and laid them onto the barrier on the over bed table. LPN #2 gloved without doing hand hygiene. LPN opened a foam dressing and	F 880			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2019
NAME OF PROVIDER OR SUPPLIER FOREST HILL NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 880	Continued From page 51 laid it back on the barrier. LPN #2 removed her gloves. LPN #2 gloved and used a bleach wipe to clean a sharpie pen she pulled out of her pocket. LPN #2 removed her gloves and LPN #2 applied gloves without performing hand hygiene and dated and initialed the dressing. LPN #2 removed her gloves and picked up a plastic drinking cup with normal saline in it and set it down on the barrier. LPN #2 reached for the hand sanitizer and she bumped the over bed table allowing the hand sanitizer to fall onto the floor. LPN #2 told CNA #2 to pick the hand sanitizer up. CNA #3 picked the sanitizer up and sat it on the barrier on the over bed table set up with supplies for catheter care. LPN #2 dropped saline in the drinking cup on the floor also. LPN #2 removed her gloves, used hand sanitizer on the wall by the door and left the room. LPN #2 went to the wound care cart and gloved and put gauze in drinking cup and poured normal saline onto the gauze in the cup. LPN #2 closed the normal saline bottle and re-entered the room. LPN #2 removed gloves worn from the hall into the room and used the hand sanitizer that fell onto the floor that was sitting on the over bedtable set up for wound care. LPN #2 gloved and assisted Resident #35 to his side with the assistance of CNA #3. LPN #2 removed her gloves and used the hand sanitizer that was picked up off the floor and placed on the over bed table for wound care. LPN #2 gloved and measured Resident #35's wound to the right Ischium. LPN #2 removed her gloves and used the hand sanitizer that had been on the floor and still sat on the table set up for wound care. The catheter bag is still lying on the foot of the bed and it remained there through out the entire process. LPN #2 gloved and wiped the wound from the inner wound area to outer area. LPN #2 did not change gloves. LPN #2 took a second	F 880			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2019
NAME OF PROVIDER OR SUPPLIER FOREST HILL NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 880	Continued From page 52 gauze and wiped from the inner area of the wound to the outer area. LPN #2 removed her gloves and used the hand sanitizer that had been picked up from the floor. LPN #2 gloved and took a dry gauze and dried the wound from inner area of the wound to the outer area of the wound. LPN #2 removed her gloves and used the hand sanitizer which was picked up from the floor earlier. LPN #2 gloved and applied Lantiseptic to the wound bed with a Q-tip applicator. LPN #2 removed her gloves and used the hand sanitizer which had been picked up from floor. LPN #2 gloved and opened a foam dressing and applied the foam dressing to the wound. LPN #2 gathered supplies and trash and exited the room. An interview, on 08/01/19 9:05 AM, with LPN #2 revealed, "I remember the hand sanitizer fell on the floor and I used it when I did wound care for Resident #35. I remember it falling and I told the CNA to pick it up and she did and I told her not to put it in my barrier but I really didn't pay attention that she put it on her barrier. But now that I think of it she did put it on her table set up for catheter care. I thought if I told her not to put it on my barrier she surely wouldn't put it on hers. I don't remember not washing my hands between gloving with Resident #35. I do remember the catheter being on the foot of Resident #35's bed during wound care. I know better and I should have told CNA #3 better. I am responsible for her actions in the room. It should have been hanging on the side of the bed that the resident was facing. The catheter lying of the bed could cause urine to go back into Residents #26 bladder and cause a UTI. It could also damage the bladder if enough urine traveled back into the bladder. The drainage bag should be below the bladder. I used the hand sanitizer several times and I can't tell	F 880			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2019
NAME OF PROVIDER OR SUPPLIER FOREST HILL NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 880	Continued From page 53 you how many times you can use it without washing your hands. I do know you should wash your hands before a procedure, throughout a procedure, when gloves are soiled and after removing gloves. An interview, on 08/01/19 at 9:15, AM with CNA #3 revealed 'I don't remember picking the hand sanitizer up off of the floor. I don't remember where I sat the sanitizer. The catheter drainage bag should have been on the side of the bed. I don't remember it being on the foot of the bed. I do remember putting the catheter bag on the lift when I assisted him up, but I don't remember where I got it from. I did use the hand sanitizer throughout the process of catheter care. When asked where the sanitizer was sitting that she used, the CNA #3 stated, "It was on my over bed table with my stuff set up on it". I do know that the catheter being on the bed and using the hand sanitizer that was picked up off of the floor is an infection control issue". An interview, on 8/01/19 at 8:10 AM, with the DON/Interim Infection Control Nurse revealed the hand sanitizer falling on the floor was an infection control issue. The DON stated the nurse should have left it on the floor and went and obtained another bottle. The DON stated LPN #2 not changing gloves from dirty to clean was an infection control issue, and LPN #2 not washing her hands between gloving is an infection control issue also. The DON state the catheter drainage bag should not have been placed on the bed at the bladder level. It could have caused a Urinary Tract Infection". Resident #35	F 880			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2019
NAME OF PROVIDER OR SUPPLIER FOREST HILL NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 880	Continued From page 54 Catheter Care An observation, on 07/31/19 at 12:00 PM, revealed Certified Nursing Assistant (CNA) #3 pulled the over bed table with catheter care supplies on it closer to Resident #35's bed. The hand sanitizer that was picked up off the floor during wound care was still sitting on the barrier on the over bed table with catheter care supplies. CNA #3 used the hand sanitizer, gloved and turned Resident #35 over on his back to perform catheter care. The catheter drainage bag was lying on the bed with 200 cc of urine in it, and the tubing was full of urine with sediment. The catheter drainage bag remained on the foot of the bed the entire process. CAN #3 removed her gloves and used the hand sanitizer that had fallen to the floor and was placed on the over bed table. CNA #3 gloved and took a gauze with normal saline on it and held the tube at the shaft of the penis and wiped up on the tubing. CNA #3 removed her gloves and used the same bottle of hand sanitizer that was picked up from the floor. CNA #3 gloved and using a dry towel, secured the tubing at the shaft of penis and wiped up on the tubing. CNA #3 removed her gloves and used the same bottle of hand sanitizer. CNA #3 gloved, secured the brief, and pulled Resident #35's pants up. CNA #3 removed her gloves and left the room for help to place Resident #35 in his wheelchair. The catheter drainage bag was still lying at the foot of Resident #35's bed. CNA #3 entered the room with LPN #2 to place Resident #35 in his wheelchair. LPN #2 and CNA #3 used the same bottle of hand sanitizer as they entered the room. Both gloved and assisted Resident #35 to a lift placing the urine drainage bag, which was lying on the bed, on the lift. The catheter lay on Resident #35's bed from 11:25 AM until 12:10 PM	F 880			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2019
NAME OF PROVIDER OR SUPPLIER FOREST HILL NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 880	Continued From page 55 with 200cc of urine in the bag and the tubing was full of urine with sediment. An interview, on 08/01/19 9:05 AM, with LPN #2 revealed, "I remember the hand sanitizer fell on the floor and I used it when I did wound care for Resident #35. I remember it falling and I told the CNA to pick it up and she did and I told her not to put it in my barrier but I really didn't pay attention that she put it on her barrier. But now that I think of it she did put it on her table set up for catheter care. I thought if I told her not to put it on my barrier she surely wouldn't put it on hers. I don't remember not washing my hands between gloving with Resident #35. I do remember the catheter being on the foot of Resident #35's bed during wound care. I know better and I should have told CNA #3 better. I am responsible for her actions in the room. It should have been hanging on the side of the bed that the resident was facing. The catheter lying of the bed could cause urine to go back into Residents #26 bladder and cause a UTI. It could also damage the bladder if enough urine traveled back into the bladder. The drainage bag should be below the bladder. I used the hand sanitizer several times and I can't tell you how many times you can use it without washing your hands. I do know you should wash your hands before a procedure, throughout a procedure, when gloves are soiled and after removing gloves. An interview, on 08/01/19 at 9:15, AM with CNA #3 revealed 'I don't remember picking the hand sanitizer up off of the floor. I don't remember where I sat the sanitizer. The catheter drainage bag should have been on the side of the bed. I don't remember it being on the foot of the bed. I do remember putting the catheter bag on the lift when I assisted him up, but I don't remember	F 880			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2019
NAME OF PROVIDER OR SUPPLIER FOREST HILL NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 880	Continued From page 56 where I got it from. I did use the hand sanitizer throughout the process of catheter care. When asked where the sanitizer was sitting that she used, the CNA #3 stated, "It was on my over bed table with my stuff set up on it". I do know that the catheter being on the bed and using the hand sanitizer that was picked up off of the floor is an infection control issue". An interview, on 8/01/19 at 8:10 AM, with the DON/Interim Infection Control Nurse revealed the hand sanitizer falling on the floor was an infection control issue. The DON stated the nurse should have left it on the floor and went and obtained another bottle. The DON stated LPN #2 not changing gloves from dirty to clean was an infection control issue, and LPN #2 not washing her hands between gloving is an infection control issue also. The DON state the catheter drainage bag should not have been placed on the bed at the bladder level. It could have caused a Urinary Tract Infection". Resident #27 An observation, on 07/31/2019 at 3:54 PM, revealed Registered Nurse (RN) #2 performed Percutaneous Endoscopic Gastrostomy (PEG) tube care. RN #2 did not apply a barrier to the table, and laid the supplies on the table. RN #2 washed her hands, applied gloves, removed the old dressing and placed it in the trash can. RN #2 cleaned the PEG tube with a wet wash cloth/soap and water and continued wearing the same gloves throughout the entire procedure. Then, RN # 2 washed her hands, applied clean gloves and applied a 4x4 gauze sponge over the PEG site. On 08/01/19 at 10:52 AM, an interview with RN #	F 880			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2019
NAME OF PROVIDER OR SUPPLIER FOREST HILL NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 880	Continued From page 57 2, regarding Resident #27's PEG Tube care revealed when she performed the PEG tube care, she should have placed a barrier down and washed her hands/change gloves more frequently at least three times. On 08/01/2019 at 4:50 PM, an interview with the Director of Nursing/Interim Infection Control Nurse, revealed hands should be washed at least three times with change of gloves to prevent cross contamination. The DON stated it was an infection control issue and she should have used the barrier also.	F 880			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255273	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - NEW WING (85) 01 B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2019
NAME OF PROVIDER OR SUPPLIER FOREST HILL NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 483.70 (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 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. 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	K 363			9/3/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

08/30/2019

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255273	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - NEW WING (85) 01 B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2019
NAME OF PROVIDER OR SUPPLIER FOREST HILL NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 1 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 REQUIREMENT is not met as evidenced by: Based on observation and testing, the facility failed to properly protect corridor openings as directed by NFPA 19 3.6.3.5. This deficiency affected one (1) of the five (5) smoke compartments and 14 of 71 residents in the facility during the survey. Findings Include: On July 30, 2019 between 10:40 AM and 11:00 AM, observation revealed the corridor doors to Rooms 200, 214, 222, and the Biohazard Room near Room 216 were unable to close to positive latching position and were unable to limit the passage of smoke throughout the facility.	K 363	K363 1. On July 30, 2019, tape obstructing proper closure of doors for rooms 200, 214, 222, and the Biohazard Room near 216 was removed by Environmental Supervisor. On July 30, 2019, 100% door audit of all facility doors were checked per Environmental Supervisor with no other issues noted. 2. Fourteen (14) of Seventy-one (71) residents residing in this facility have the potential to be affected by this deficient practice. 3. On July 31, 2019, Environmental Supervisor started room checks to ensure all doors would close properly five days per week. 4. On July 31, 2019, Environmental Supervisor started room checks five times per week for proper closer for three months. On July 30, 2019, Environmental Supervisor began in-service for all staff regarding Life Safety Code compliance with proper closure of doors within the		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255273	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - NEW WING (85) 01 B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2019
NAME OF PROVIDER OR SUPPLIER FOREST HILL NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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	K 363	facility. No staff will be allowed to work until in-serviced. The facility Environmental Supervisor will monitor compliance for three months. Any issue will be brought to the Administrator immediately to be addressed. The Quality Assurance (QA) Committee will be informed of any findings for a recommendation in the quarterly meeting.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2019
NAME OF PROVIDER OR SUPPLIER FOREST HILL NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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
E 000	Initial Comments ***** Survey conducted on 07/30/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were cited.	E 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

08/30/2019

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.