STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A402	A. BUILDING _____ B. WING _____	09/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JNH-JEFFERSON INN	3550 HWY 468 WEST - PO BOX 207 BLDGS 29 &33 WHITFIELD, MS 39193

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an Annual Recertification Survey from 9/24/18 through 9/26/18. During the survey, the SA determined the facility failed to meet the requirements of participation for Medicare and Medicaid. The SA cited deficiencies at F604, F641, F656, F800, F808, and F880. The census at the time of the survey was 44. The facility was licensed for 86 beds.	F 000		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §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. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for	F 604		11/16/18

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

Electronically Signed | 10/29/2018

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.

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F 604	Continued From page 1 purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure that one (1) resident out of three (3) residents reviewed for the use of physical restraints was assessed for unnecessarily restricting the resident's movements with the least restrictive method of restraint: Resident #27 Specifically, the facility failed to: 1. Obtain a physician's order for the use of a physical restraint; 2. Assess the use of side rails as a potential physical restraint; and 3. Care plan the use of side rails as a physical restraint. Findings include: A review of the clinical record of Resident # 27 revealed he had diagnoses that included restlessness and agitation, Major Depressive Disorder, Personal History of Traumatic Brain Injury (TBI) and Personal History of Self-Harm. On 09/25/18 - 09/26/18, the resident was observed multiple times sitting in a chair in his room with a pelvic restraint in place. Full side rails were observed on the resident's bed. On 09/26/18 at 12:57 PM, the Director of Nursing (DON) was asked if full side rails were used for Resident #27 when he was in bed. She stated	F 604	A. What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice? On 09/26/2018, the Director of Nursing(DON) reviewed Resident #27's chart and instructed the Registered Head Nurse(RHN) to obtain an updated revised order for side rails X2 to be used for positioning for Resident #27. On 09/26/2018, the Minimum Data Set(MDS) Nurse reviewed the revised Physician's Order and updated Resident #27's Care Plan for side rail usage as a positional device. On 09/26/2018, the (DON) re-educated the MDS Nurse on the importance of verifying that the care plans reflect the Physician Orders. On 10/01/2018, the MDS Nurse modified the existing MDS removing side rails as a restraint for Resident #27. B. How will you identify other residents having the potential to be affected by the same deficient practice, and what corrective action(s) will be taken? On 09/26/2018, the DON and the MDS	

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F 604	Continued From page 2 side rails were used when the resident was in bed. She was asked if there was a physician's order for the use of side rails as a restraint. The DON stated the care plan documented side rails were used for positioning. The DON was asked what would happen to the resident if the side rails were not up. The DON did not answer. On 09/26/18 at 1:14 PM, Registered Nurse (RN) #2 was asked if side rails were used for the resident when he was in bed. She stated, "Yes." She was asked for what the reason the side rails were used for the resident. She stated, "Safety perimeters. He's not aware of safety." The RN was asked what would happen if the side rails were not up. She stated, "He'd walk out of the room, walk into someone else's room or fall and hurt himself." She was asked if the side rails would be considered a restraint. The RN stated, "I thought they were for safety perimeters." The surveyor asked the RN if she had ever seen or heard of the resident having crawled out the end of the bed or over the side rails. She stated, "No." She was asked if the use of a restraint required a physician's order. She stated, "Yes, it does." On 09/26/18 at 1:21 PM, Certified Nurse Aide #1 was asked if she had ever seen or heard of the resident having crawled out the end of the bed or over the side rails. She stated, "No." On 09/26/18 at 1:23 PM, RN #3 was asked if she had ever seen or heard that Resident #27 had crawled or attempted to crawl out the foot of the bed and/or over the side rail. She stated, "No." On 09/26/18 at 01:33 PM, the DON returned and again stated the bed rails were care planned for	F 604	Nurse reviewed the census, 13 of 44 residents had the potential to be affected by the deficient practice. No others were affected. C. What measures will be put into place, or what systemic changes you will make to ensure that the deficient practice does not recur? Beginning 09/26/2018 the Staff (RHN) will use Jefferson Inn Positioning/Restraint/Protective Device Checklist to monitor and track side rail assessments, physician orders, consent for side rails and changes to care plans weekly. Any deficiencies found will be reported to the DON weekly. Beginning 09/27/2018 and ending 10/17/2018, the DON in-serviced the Jefferson Inn Certified Nursing Assistant(CNA) Staff and Licensed Nurse Staff on Jaquith Nursing Home (JNH) Policy(J530-65) Resident's Rights emphasizing the right to be free from restraints and usage of side rails as positioning devices per Physician's Orders. On 10/17/2018, the DON in-serviced the RHN and MDS Nurse on verifying that all care plans follow Physician's Orders, Physician's Orders are reflected in the MDS, and Side Rail Assessment and Consent forms are updated. Beginning 10/17/2018, the Staff RN will use the Jefferson Inn Positioning/Restraint/Protective Device Checklist to verify that all assessments, consents and care plans reflects the revised Physician's orders weekly for 30 days, then bi-weekly for 60 days. Any	

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F 604	Continued From page 3 positioning. She was informed about the interview with RN #2 and her statement that the resident would get up out of bed and ambulate and might fall or go into someone's room if the side rails were not up. She was informed the intent of the side rails might be for positioning but the effect of the side rails on the resident was that they kept him getting out of bed. The DON stated, "I understand what you're saying." The DON was asked to provide incident reports of all of the resident's incident and accidents for the past year. On 09/26/18 at 2:11 PM, the DON stated the resident had not fallen since 10/20/16. She was asked to provide a physician's order for the side rail as a restraint, a side rail assessment, and consents which documented the risks and benefits of the use of a restraint for both the pelvic restraint and the side rails. On 09/26/18 at 2:35 PM, the DON returned with the informed consent for the pelvic restraint. She was asked if there was an informed consent document for the use of the side rails. She stated, "No." She was asked if a side rail assessment had been completed. She stated, "No." On 09/26/18 at 2:49 PM, the Minimum Data Set (MDS) Coordinator was reminded that the quarterly MDS assessments, dated 05/31/18 and 08/23/18, documented that side rails were used daily as restraints. She was asked if the comprehensive care plan addressed the use of side rails a restraint and included goals and interventions for the use of side rails as a restraint. She stated the care plan did not address the use of side rails as a restraint. She	F 604	newly ordered restraints and Protective Devices will be discussed during weekly treatment team meetings and verified on the care plan. The DON will review the checklist weekly for 90 days then quarterly there after. D. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance will be put into place? If any deficiencies are found in the documented checklist observation of restraints, side rails and protective devices, the RHN and MDS Nurse will be re-educated by the DON. The DON will report findings to the Jefferson Inn Nursing Home Administrator (NHA) weekly. The NHA will report to the Jaquith Nursing Home (JNH) monthly Executive Committee Meeting and the quarterly JNH Quality Assurance Performance Improvement (QAPI) Committee meeting the progress and effectiveness of the corrected actions. Should systemic changes not be effective QAPI will investigate and determine further action(s) to be implemented. The corrective action will be completed on November 16, 2018.	

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F 604	Continued From page 4 stated the DON had told her the side rails were used for positioning and that she should not have indicated the side rails were a restraint on the MDS assessments. On 09/26/18 at 3:16 PM, the DON was asked if full side rails were required for use as a positioning device or if a ¼ side rail would be a better choice. She stated, "We don't have those beds. This is a state facility and we don't have those beds." She was asked if an ongoing assessment was conducted to ensure the least restrictive restraint was used for the least amount of time? She stated, "No." The DON was asked if there was any more restraint documentation available. She stated, "No. Not to my knowledge." On 09/26/18 at 4:07 PM, the MDS coordinator was shown the pelvic restraint consent, dated 05/30/17, and was asked if the care plan had been followed to get consent annually. She stated, "No." An "Informed Consent for Use of Restraint Devices," documented the resident's responsible party had given informed consent for the use of a pelvic restraint and a soft helmet on 05/30/17. There was no documentation in the clinical record which indicated informed consent had been obtained for the pelvic restraint and soft helmet since 05/30/17. The annual MDS assessment, dated 03/08/18, documented the resident had severe cognitive impairment, had exhibited no behaviors and required limited assistance with bed mobility. The assessment documented a trunk restraint was	F 604		

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F 604	Continued From page 5 used daily and an "other" restraint was used less than daily when in the chair or out of bed. The quarterly MDS assessment, dated 05/31/18, documented in the section of "Restraints" that side rails and a trunk restraint were used daily. The assessment documented an "other" restraint was used less than daily when in chair or out of bed. The care plan, most recently reviewed/revised 06/08/18, documented the resident had impaired cognitive status related to severe traumatic brain injury with confusion, severely impaired decision-making skills and long & short-term memory problems. The care plan addressed problems of the resident's impaired communication and high risk for falls or injuries related to his unsteady gait without assistance secondary to severe traumatic brain injury and attempts to get up without assistance. The care plan documented a problem related to "safety devices/restraints: side rails up X2 when in bed for [positioning] pelvic restraint when out of bed while up in chair for safety 2nd [secondary] to poor safety awareness [related to] severe TBI attempting to get up without assist. severe traumatic brain injury with confusion. Soft helmet to be worn during ambulation. Risk for injury or death [related to] self-mutilation (biting/hitting/scratching self/[banging] head against anything he gets close to), [history] of physical aggression, pelvic restraint usage. An intervention for the problem was to obtain "Restraint consent yearly." The care plan documented the resident had a problem related to "Safety devices and risk for	F 604		

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F 604	Continued From page 6 injury related to the use of pelvic restraint ...when out of bed ...Side rail up X2 when in bed for safety and define perimeters of the bed." An intervention for the problem was "side rails up X2 when in bed for safety and to define perimeters of the bed. The care plan documented a problem related to the resident's "high risk for falls or injuries [related to] unsteady gait without assist 2nd [secondary] to get up without assist ...pelvic [restraint] when out of bed, Side rails up x2 when in bed ..." An intervention for the problem was "side rails up x2 when in bed for safety and to define the perimeters of the bed." A physician's order, dated 06/29/18, documented: "Activities. Fall Precautions: ... [Side rails] up x2 for positioning while in bed ..." The quarterly MDS assessment, dated 08/23/18, documented in the section of "Restraints" that side rails and a trunk restraint were used daily. The assessment documented an "other" restraint was used less than daily when in chair or out of bed. The resident's clinical record contained no pre-restraint assessment for the use of side rails, no informed consent for the use of the side rails, no physician's order for the use of the side rails as a restraint, no care plan for the use of the side rails as a restraint, and no monthly assessment by the treatment team for the use of the side rails. A physician's order, dated 09/19/18, documented the following: "Pelvic restraint while in bed to prevent getting up unassisted and falls/injury. [Diagnosis]: TBI- unsteady gait and inability to	F 604		

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F 604	Continued From page 7 recognize potential hazards to self ..." The facility's "Restraints" policy and procedure documented: "Policy. Each resident has the right to be free from any physical or mechanical restraint imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms ...Definitions ...Physical restraint is defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to a resident's body, which the individual cannot remove easily, and that restricts freedom of movement or normal access to one's body ...Side Rails- rails attached to the resident's bed frame. When used for the purpose of keeping a resident from getting out of bed and the resident wants to get out of bed, side rails meet the definition of physical restraint ..." The restraint policy and procedure documented informed consent for the use of a restraint would be given to the resident and/or the resident's designated representative. It documented the consent would be updated annually with the resident's annual Resident Assessment Inventory process. It documented the nurse would document the use of the restraint in the resident's care plan and document the status of the restraint usage in the monthly nurse's notes. The policy and procedure documented the need for restraints would be re-evaluated by the treatment team at least monthly.	F 604		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the	F 641		11/16/18

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F 641	Continued From page 8 resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and review of the Resident Assessment Instrument (RAI) 3.0 Manual, the facility failed to accurately code Resident #46's Minimum Data Set (MDS) for discharge. This concern was identified for one (1) of 15 MDS assessments reviewed. Findings include: The facility refers to the Center for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual for completing the MDS assessments. A review of the RAI version 3.0 Manual, dated October 2017, under section 1.3 Completion of the RAI revealed: It is important to note that information obtained should cover the same observation period as specified by the MDS items on the assessment, and should be validated for accuracy (what the resident's actual status was during that observation period) by the Interdisciplinary Team (IDT) completing the assessment. As such, nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment. Review of Resident #46's Non-Prospective Payment System (PPS) MDS, with an Assessment Reference date of 09/08/18, revealed Resident #46 was admitted by the facility on 10/29/08, and was discharged on 9/8/18. The MDS assessment was coded for Discharge Return Not Anticipated with an Assessment Reference. This Discharge Return Not Anticipated MDS assessment with an ARD of	F 641	A. What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice? On 09/26/2018, the Minimum Data Set(MDS) Nurse, through the MDS 3.0 System inactivated the Discharge Return Not Anticipated Assessment and completed the Death in Facility Record with the Assessment Reference Date of 09/08/2018 for Resident #46. B. How will you identify other residents having the potential to be affected by the same deficient practice, and what corrective action(s) will be taken? On 09/26/2018, the MDS Nurse and Director of Nursing (DON) reviewed the census and 44 of 44 residents have the potential to be affected by the deficiency. No others were affected. C. What measures will be put into place, or what systemic changes you will make to ensure that the deficient practice does not recur? On 09/26/2018, the DON in-serviced the MDS Nurse on the MDS 3.0 Manual, Chapter 2, pages 1-88, Assessment Types and definitions Section with emphasizes on correct coding guidelines according to the MDS 3.0 Manual. On	

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F 641	Continued From page 9 9/8/18, should have been a Death in Facility Record with an ARD of 9/8/18. Review of Resident #46's Physician's Orders, dated June 29, 2018 revealed: A Full Code Status with no artificial ventilation by any tube and he was on hospice care. Resident #46's diagnoses included: Prostate Cancer, Schizophrenia, Personality Disorder, Antisocial, Partial Amputation of Left Foot, and Bilateral Above the Knee Amputation (BAKA). Review of the Death Certificate revealed the date of death was 09/08/18, and the death summary was complete. On 9/26/18 at 11:50 AM, an interview with Registered Nurse (RN) #5, revealed Resident #46 talked in the third person, and the resident was able to participate in his Activities of Daily Living (ADL) care. RN #5 also stated Resident # 46 was able to feed himself, assist with his incontinent care, and make his needs known to staff. She stated Resident #46 became ill possibly with a cancer mass, and was placed on hospice care. RN #5 stated he (Resident # 46) declined, and passed away. She stated Resident #46 coded here in Building #33, and expired in Building #60, which is the hospital. On 9/26/18 at 12:25 PM, an interview with RN #4, revealed A Death in Facility Record should be done within 7 days of the death of a resident. She also stated you would only do a Death in Facility Record when a death occurs in the facility. RN #4 then stated she would check to be sure when a Death in Facility Record is indicated. On 9/26/18 at 12:45 PM an interview with RN#4	F 641	09/26/2018, the MDS Nurse revised Resident #46 MDS to correct the deficient practice. When a new discharge for a death is noted, the MDS Nurse will use the Jefferson Inn Discharged Resident Checklist to ensure that the correct coding has been listed in the MDS. Any deficiencies will be reported to the DON for corrective actions. On October 9, 2018 the MDS Nurse attended the MDS 3.0 October 2018 Updates training and will attend the Myers and Stauffer's Case Mix Training on October 30, 2018. These trainings will continue to allow the MDS Nurse to gain and apply knowledge to on the MDS System. Beginning 10/22/2018 and ending 03/22/2019, the MDS Nurse will use the Jefferson Inn Discharged Residents Checklist weekly to verify that all discharged residents are coded according to the MDS 3.0 Manual. The MDS Nurse will document the weekly audits on the Discharged Residents Checklist. Any deficiencies will be addressed by the DON. Beginning 10/26/2018, during weekly Treatment Team meetings, the MDS Nurse will review the current discharged residents, the type of discharge and note that the MDS has been coded and entered. Any deficiencies found will be promptly corrected by the MDS Nurse and reported to the DON. D. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance will be put into place?	

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F 641	Continued From page 10 revealed, "I did that wrong, I should have done a Death in Facility Record." RN #4 stated she would inactivate the Discharge Return Not Anticipated Assessment and complete the Death in Facility Record. On 9/26/18 at 2:45 PM, an interview with the RN #5, revealed she would expect the MDS nurse to code the MDS according to the MDS 3.0 *regulations*. RN #5 also stated the facility does not have a policy on the MDS, but the facility follows the MDS guidelines for the completion of the MDS. A review of the facility's Face Sheet revealed, Resident #46 was admitted, on 10/29/08, with the included diagnoses Schizophrenia, Personality Disorder, Partial Amputation of Left Foot, and Bilateral Above the Knee Amputation (BAKA).	F 641	The DON will report findings to the Jefferson Inn Nursing Home Administrator (NHA) weekly. The NHA will report to the Jaquith Nursing Home (JNH) monthly Executive Committee Meeting and the quarterly JNH Quality Assurance Performance Improvement (QAPI) Committee meeting the progress and effectiveness of the corrected actions. Should systemic changes not be effective QAPI will investigate and determine further action(s) to be implemented. The corrective action will be completed on November 16, 2018.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required	F 656		11/16/18

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JNH-JEFFERSON INN	3550 HWY 468 WEST - PO BOX 207 BLDGS 29 &33 WHITFIELD, MS 39193

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F 656	Continued From page 11 under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to develop and implement a comprehensive care plan for the use of bed rails as a physical restraint for one (1) of 15 sampled residents whose care plans were reviewed: Resident #27 Findings: The facility's "Restraints" policy and procedure documented informed consent for the use of a restraint would be given to the resident and/or the resident's designated representative. It	F 656	A. What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice? On 09/26/2018, the Director of Nursing (DON) reviewed Resident #27's chart and instructed the Registered Head Nurse(RHN) to obtain an updated revised order for side rails X2 to be used for positioning. On 09/26/2018, the DON in-serviced the RHN on care plans and the importance of updating assessments,	

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F 656	Continued From page 12 documented the consent would be updated annually with the resident's annual Resident Assessment Inventory process. It documented the nurse would document the use of the restraint in the resident's care plan. A review of the clinical record of Resident # 27 revealed he had diagnoses which included restlessness and agitation, major depressive disorder, personal history of traumatic brain injury (TBI) and personal history of self-harm. The annual Minimum Data Set (MDS) assessment, dated 03/08/18, documented the resident had severe cognitive impairment, had exhibited no behaviors and required limited assistance with bed mobility. The MDS documented a trunk restraint was used daily and an "other" restraint was used less than daily when in the chair or out of bed. The quarterly MDS assessment, dated 05/31/18, documented in the section of "Restraints" that side rails and a trunk restraint were used daily. The assessment documented an "other" restraint was used less than daily when in chair or out of bed. The care plan, most recently reviewed/revised 06/08/18, documented the resident had impaired cognitive status related to severe traumatic brain injury with confusion, severely impaired decision-making skills and long & short-term memory problems. The care plan addressed problems of the resident's impaired communication and high risk for falls or injuries related to his unsteady gait without assistance secondary to severe traumatic brain injury and	F 656	obtaining consents, and reviewing up to date Physician's Orders for restraints where as the resident has a medical symptom that warrant the use of restraints. B. How will you identify other residents having the potential to be affected by the same deficient practice, and what corrective action(s) will be taken? The RHN and the MDS Nurse reviewed the Physician's orders for restraints and Care Plans, 20 of 44 residents had the potential to be affected by the deficient practice. No others were affected. C. What measures will be put into place, or what systemic changes you will make to ensure that the deficient practice does not recur? The DON and the MDS Nurse will conduct trainings two (2) times a year on the importance of updating care plans, obtaining necessary consents, assessment and proper documentation with emphases on restraints, protective devices and positioning. The training will be completed in November 2018 and May 2019. Beginning October 22, 2018, Resident care plans will be checked weekly by the RHN for the next three (3) months, then monthly for the next nine (9) months to ensure care plan accuracy. The results will be documented on the Jefferson Inn Care Plan Checklist and provided to the DON for any necessary	

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F 656	Continued From page 13 attempts to get up without assistance. The care plan documented a problem related to "safety devices/restraints: side rails up X2 when in bed for [positioning] pelvic restraint when out of bed while up in chair for safety 2nd to poor safety awareness [related to] severe TBI attempting to get up without assist. severe traumatic brain injury with confusion. Soft helmet to be worn during ambulation. Risk for injury or death [related to] self-mutilation (biting/hitting/scratching self/[banging] head against anything he gets close to), [history] of physical aggression, pelvic restraint usage. An intervention for the problem was to obtain "Restraint consent yearly." The care plan documented the resident had a problem related to "Safety devices and risk for injury related to the use of pelvic restraint ...when out of bed ...Side rail up X2 when in bed for safety and define perimeters of the bed." An intervention for the problem was "side rails up X2 when in bed for safety and to define perimeters of the bed. The care plan documented a problem related to the resident's "high risk for falls or injuries [related to] unsteady gait without assist 2nd to get up without assist ...pelvic [restraint] when out of bed, Side rails up x2 when in bed ..." An intervention for the problem was "side rails up x2 when in bed for safety and to define the perimeters of the bed." A physician's order, dated 06/29/18, documented: "Activities. Fall Precautions ... [Side rails] up x2 for positioning while in bed ..."	F 656	follow-up actions weekly. Any newly hired nurses will be in-serviced during their building orientation. Any nurse found to be non-compliant will be re-directed and reeducated on correct procedures for care planning positioning, restraints, and protective devices by the RHN. D. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance will be put into place? The DON will report findings weekly for the next 3 months, then monthly for the next 9 months to the Jefferson Inn Nursing Home Administrator (NHA). The NHA will report to the Jaquith Nursing Home (JNH) monthly Executive Committee Meeting and the quarterly JNH Quality Assurance Performance Improvement (QAPI) Committee meeting the progress and effectiveness of the corrected actions. Should systemic changes not be effective QAPI will investigate and determine further action(s) to be implemented. The corrective action will be completed on November 16, 2018.	

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F 656	Continued From page 14 The quarterly MDS assessment, dated 08/23/18, documented in the section of "Restraints" that side rails and a trunk restraint were used daily. The assessment documented an "other" restraint was used less than daily when in chair or out of bed. The care plan did not address the use of side rails as a restraint. A physician's order, dated 09/19/18, documented the following: "Pelvic restraint while in bed to prevent getting up unassisted and falls/injury. [Diagnosis]: TBI- unsteady gait and inability to recognize potential hazards to self ..." On 09/25/18 - 09/26/18, the resident was observed multiple times sitting in a chair in his room with a pelvic restraint in place. Full side rails were observed on the resident's bed. On 09/26/18 at 01:14 PM, registered nurse (RN) #2 was asked if side rails were used for the resident when he was in bed. She stated, "Yes." She was asked for what the reason the side rails were used for the resident. She stated, "Safety perimeters. He's not aware of safety." The RN was asked what would happen if the side rails were not up. She stated, "He'd walk out of the room, walk into someone else's room or fall and hurt himself." She was asked if the side rails would be considered a restraint. The RN stated, "I thought they were for safety perimeters." On 09/26/18 at 01:33 PM, the Director of Nursing (DON) stated the bed rails were care planned for positioning. She was informed about the interview with RN #2 and her statement that the resident would get up out of bed and ambulate	F 656		

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F 656	Continued From page 15 and might fall or go into someone's room if the side rails were not up. She was informed the intent of the side rails might be for positioning but the effect of the side rails on the resident was that they kept him getting out of bed. The DON stated, "I understand what you're saying." On 09/26/18 at 02:49 PM, the MDS coordinator was reminded that the quarterly MDS assessments, dated 05/31/18 and 08/23/18, documented that side rails were used daily as restraints. She was asked if the comprehensive car plan addressed the use of the side rails a restraint and included goals and interventions for the use of side rails as a restraint. She stated the care plan did not address the use of side rails as a restraint. She stated the DON had told her the side rails were used for positioning and that she should not have indicated the side rails were a restraint on the MDS assessments. On 09/26/18 at 04:07 PM, the MDS coordinator was shown the pelvic restraint consent, dated 05/30/17, and was asked if the care plan had been followed to get consent annually. She stated, "No."	F 656		
F 800 SS=D	Provided Diet Meets Needs of Each Resident CFR(s): 483.60 §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and record review, the facility failed to	F 800	A. What corrective actions(s) will be accomplished for those residents found to	11/16/18

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F 800	Continued From page 16 provide the condiments Resident #7 preferred on the meal tray for one (1) of two (2) meals observed. Findings include: Review of a typed statement, on the facility's letterhead, signed and dated by the Administrator revealed the facility did not have a policy that outlines a two-step process, and verification of diet cards prior to consumption. On 09/26/18 at 8:10 AM, an observation of the breakfast meal revealed Resident #7 was served pancakes, bacon, cereal, juice, coffee, eggs margarine, creamer, sugar, butter, and syrup. On 09/26/18 at 8:12 AM, an interview with Resident #7 revealed he wanted some salt for his eggs. Resident #7 stated he never gets salt and pepper on his tray. An observation and interview, on 09/26/18 at 8:20 AM, with the Coordinator of Unit Operations (CUO) confirmed Resident #7 did not have salt or pepper on his tray. The CUO stated the tray set ups occurred in the pantry, and when the trays are delivered to the residents, the staff member who sets up the tray was responsible for checking the dietary card to ensure all items are on the tray. Review of Resident #7's Meal ticket for breakfast, dated 9/26/18, revealed one (1) salt packet and one (1) pepper packet should have been on Resident #7's tray. Review of Resident #7's Physician's Orders revealed an order, dated 09/13/18, to upgrade his	F 800	have been affected by the deficient practice? On 09/26/2018, The Coordinator of Unit Operations (CUO)checked Resident #7's tray and reported that Resident #7 had consumed all items. By the next meal, Resident #7 received all listed items from the tray ticket. On 09/26/2018, the CUO checked Resident #7's Tray Ticket, Diet Order and his meal tray to verify that what was ordered and listed was provided to Resident #7. On 09/26/2018, the CUO in-serviced the three (3) Food Service Workers on the importance that all residents have the prescribed food and condiment items listed on the tray ticket. B. How will you identify other residents having the potential to be affected by the same deficient practice, and what corrective action(s) will be taken? On 09/26/2018, the CUO and Clinical Dietician reviewed Mississippi State Hospital (MSH) Tray tickets for all 3 meals. 43 of 44 residents were identified as having the potential to be affected. No other was affected. C. What measures will be put into place, or what systemic changes you will make to ensure that the deficient practice does not recur? Beginning 09/26/2018 and ending 10/15/2018, the CUO in-serviced the Jefferson Inn Staff including Direct Care Trainees(DCT), Certified Nurse Assistant(CNA), Licensed Nurse Staff,	

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F 800	Continued From page 17 diet to a Regular diet from a Mechanical Soft diet. An interview, on 9/26/18 at 8:30 AM, with Registered Nurse (RN) #2, revealed the Certified Nursing Assistant (CNA) checked the tray and meal ticket first, and then she (RN #2) checked it behind her. RN #2 stated she couldn't explain why there was no salt and pepper on Resident #7's tray, and she guessed the pantry must have missed putting the salt and pepper on the tray and she missed it too. RN #2 stated she usually just checks the diet and allergies. An Interview, on 9/26/18 at 12:40 PM, with Dietary Staff #3, revealed the seasonings for Resident #7's tray were overlocked. An interview, on 9/26/18 at 12:45 PM, with the CUO, confirmed the pantry staff was responsible for setting up the trays according to the meal ticket. The CUO stated she felt the staff was probably nervous. An interview, on 9/25/18 at 2:45 PM, with Certified Nursing Assistant (CNA) #1, confirmed she set up Resident #7's tray at breakfast. CNA #1 stated she was supposed to read the menu, and set everything up for the resident. CNA #1confirmed she should have noticed the salt and pepper was not on the tray, and should have asked for some from the kitchen. Review of the Identification and Summary Sheet revealed Resident #7 was admitted by the facility, on 05/09/17, with the included diagnoses Bipolar Disorder, Chronic Obstructive Pulmonary Disease, and Gastric Esophageal Reflux Disease.	F 800	Social Worker, Recreational Staff emphasizing the importance of providing prescribe condiments for each resident's meal. The CNA Staff will verify that all items listed on the tray ticket are on the Resident's tray before placing the meal in front of the Resident. The CUO will use the Jefferson Inn Tray Ticket Checklist for Condiments weekly to verify that residents are receiving what has been ordered per their diet. Any deficiencies found will be immediately addressed with Food Service staff and reported to Jefferson Inn Nursing Home Administrator. Beginning 10/22/2018, the CUO will observe the Food Service Workers and CNAs while providing meals at breakfast, lunch and dinner(breakfast @ 7:45 A.M., lunch @ 12:45 P.M., and Dinner @ 5:45 P.M.)weekly for 60 days, then monthly for 90 days. Any deficient issues noted will be corrected at that time and reported to the DON. Any Food Service Worker found to be deficient will receive additional in-servicing and be observed weekly for one month or until they are able to demonstrate having knowledge of following instructions and Physician's orders as outlined on the Resident's tray tickets. The DON will review the checklist documentation weekly for 60 days then monthly for 90 days. All newly hired Food Service Workers and CNAs, and Nurses will be in-serviced on Providing the Diet Meets the Need of each Resident. D. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance	

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F 800	Continued From page 18	F 800	will be put into place? The DON will report findings to the Jefferson Inn Nursing Home Administrator (NHA)weekly. The NHA will report to the Jaquith Nursing Home (JNH) monthly Executive Committee Meeting and the quarterly JNH Quality Assurance Performance Improvement (QAPI) Committee meeting the progress and effectiveness of the corrected actions. Should systemic changes not be effective QAPI will investigate and determine further action(s) to be implemented. The corrective action will be completed on November 16, 2018.	
F 808 SS=D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, facility policy review, and record review, the facility failed to upgrade Resident #7's diet as ordered by the physician, for one (1) of thirteen residents reviewed on sample.	F 808	A. What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice? On 09/25/2018, the Registered Dietician	11/16/18

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F 808	Continued From page 19 Findings include: Review of the facility's policy titled, "Diet Orders and Diet Changes", dated April 2018, revealed the purpose and applicability of this policy is to establish guidelines for ordering diets for residents of the (Name of Facility). The policy revealed any dietary regimen served to a patient/resident will be ordered by the attending physician or nurse practitioner. The equipment needed for the process included, the Nutritional Status Change MSH-608 (diet change form used by all applicable divisions which included (Name of Facility), and the Diet List Form MSH 248. An observation, on 09/25/18 at 1:00 PM, revealed Resident #7 was in the dining room eating a meal that consisted of chopped ground beef, mashed potatoes, brussel sprouts, roll, jello salad and tea. Resident #7 put his fork in the ground meat, and said he couldn't eat that. Resident #7 ate the jello salad. Review of Resident #7's Physician's Orders, dated June 29, 2018, revealed an order for a Mechanical Soft diet with chopped meats. Review of a Physician's Order, dated 09/13/18, revealed the order to upgrade to a Regular diet. On 09/25/18 at 4:05 PM, an interview with Registered Dietician (RD) #1, who was the Clinical Dietician for Building #33, stated she was not notified of the consult to upgrade Resident #7's diet. She stated she usually sees Resident #7 once a month, and his routine consult was due this month. RD #1 confirmed Resident #7's diet on the diet sheet had not been upgraded, and the most recent physician's order revealed an	F 808	reviewed the revised diet order and upgraded Resident #7 diet to a Regular Diet by the evening's meal. B. How will you identify other residents having the potential to be affected by the same deficient practice, and what corrective action(s) will be taken? On 09/26/2018, the Director of Nursing and Registered Head Nurse(RHN) reviewed the census and 44 of 44 residents had the potential to be affected. No others were affected. C. What measures will be put into place, or what systemic changes you will make to ensure that the deficient practice does not recur? On 09/27/2018, the DON in-serviced all Licensed Nurses, Health Record Clerks, Pantry Coordinator and Pantry Supervisor (CUO) on Mississippi State Hospital(MSH) Policy (MSH210-76) Diet Orders and Diet Changes, MSH Policy (MSH210-74) Diet List, and MSH Policy (MSH608) Nutritional Status Change to re-educate on the correct procedures to make changes to a resident's diet orders. Beginning 10/22/2018, Jefferson Inn's Health Records Clerk and Pantry Coordinator will use the Jefferson Inn Diet Order/Diet List Checklist weekly to check for accuracy of the diet list for 90 days. Jefferson Inn Staff RHN will review the findings weekly for 90 days and then bi-weekly for 90 days. Any deficiencies	

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F 808	Continued From page 20 upgrade in the resident's diet to a Regular diet. An interview, on 09/25/18 at 4:35 PM, with Registered Dietician (RD) #2 confirmed the staff should call and notify dietary of a diet change so the diet can be changed on the diet sheet. RD #2 stated there is a status change form the staff should fill out, and place in her box at the nurses desk when a diet is changed. RD #2 confirmed the mechanical soft diet with chopped meats listed on the diet sheet for Resident #7, did not indicate the most recent order change in his diet. An interview, on 9/26/18 at 2:50 PM, with Licensed Practical Nurse (LPN) #1, confirmed she had signed off the order. LPN #1 confirmed she had called dietary, and left a message concerning the new order. LPN #1 confirmed she did not document this call in the nurses notes. LPN #1 stated she had planned to call dietary back, but she guessed it just slipped her mind. LPN #1 stated she was not aware of a policy and procedure for notifying dietary of changes. During an interview, on 9/26/18 at 2:55 PM, RN #5 stated they do not have a policy and procedure for notifying the dietician. An interview, on 9/26/18 at 3:15 PM, with the Director of Nursing (DON) confirmed the facility had a policy and procedure for diet order changes. The DON stated the nurse signing off the order should call dietary and tell them about the order change or leave a message, and then fill out a nutritional change form and put it in the RD box at the nurses desk. Review of the Identification and Summary Sheet revealed Resident #7 was admitted by the facility, on 05/09/17, with the included diagnoses Bipolar	F 808	will be addressed and corrected by the Registered Nurse. Newly hired Jefferson Inn nurses, Health Records Clerks and Pantry Coordinators will be in-serviced during their building orientation. Beginning 10/25/2018, during weekly Treatment Team meetings the Staff RN will review any diet changes, upgrades for 90 days, then monthly there after. Any deficiencies will be addressed by the DON. D. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance will be put into place? The DON will report findings to the Jefferson Inn Nursing Home Administrator (NHA) weekly. The NHA will report to the Jaquith Nursing Home (JNH) monthly Executive Committee Meeting and the quarterly JNH Quality Assurance Performance Improvement (QAPI) Committee meeting the progress and effectiveness of the corrected actions. Should systemic changes not be effective QAPI will investigate and determine further action(s) to be implemented. The corrective action will be completed on November 16, 2018.	

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	25A402	A. BUILDING _____ B. WING _____	09/26/2018

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F 808	Continued From page 21 Disorder, Chronic Obstructive Pulmonary Disease, and Gastric Esophageal Reflux Disease.	F 808		
F 880 SS=D	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 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	F 880		11/16/18

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F 880	Continued From page 22 reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed 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 observation and interview, the facility failed to ensure staff used proper hand hygiene to prevent cross-contamination during the medication pass for three (3) of five (5) residents observed during the medication pass. (Residents #2, #25 and #41)	F 880	A. What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice? On 09/26/2018, the Director of	

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F 880	Continued From page 23 Findings: On 09/26/18 at 7:29 AM, Registered Nurse (RN) #1 was observed as she set up 10 oral medications for administration to Resident #41. The RN used hand gel and donned gloves prior to beginning the set up. With her gloved hands, she proceeded to open/close medication cart drawers, handle the medication containers, flip her hair multiple times and touch her face one time. She removed the medications from the containers or blister packs with her gloved fingers and dropped them into the medication cup. On 09/26/18 at 7:36 AM, RN #1 was observed as she set up seven oral medications for administration to Resident #25. The RN used hand gel and donned gloves prior to beginning the set up. With her gloved hands, she proceeded to open/close medication cart drawers and handle the medication containers. She removed the medications from the containers with her gloved fingers and dropped them into the medication cup. On 09/26/18 at 7:45 AM, RN #2 was observed as she set up five oral medications for administration to Resident #2. The RN used hand gel and donned gloves prior to the set up. With her gloved hands, she proceeded to open/close the medication cart drawers and removed the medications from the containers with her gloved fingers and dropped them into the medication cup. On 09/26/18 at 8:12 AM, the above findings regarding medication set up for Residents #41 and #25 were reviewed with RN #1. She was	F 880	Nursing(DON) re-educated Registered Nurse #1 and Registered Nurse #2 on the proper medication administration and Hand Hygiene protocol. On 09/27/2018, Resident #41 was assessed by DON. Resident #41 denied any compliant of nausea and or vomiting at the time of assessment. Resident #2 and Resident #25 identity was not know until after the survey report was issued. The DON reviewed Resident #2 and Resident #25's chart for charting on the days following annual survey for any findings of discomfort. No negative findings were noted. B. How will you identify other residents having the potential to be affected by the same deficient practice, and what corrective action(s) will be taken? On 09/27/2018, Jefferson Inn DON reviewed the census and identified 43 of 44 residents receiving medication had the potential to be affected. None others were found to be affected. C. What measures will be put into place, or what systemic changes you will make to ensure that the deficient practice does not recur? On 09/27/2018, the DON in-serviced the Staff Registered Nurses and Licensed Practical Nurses on Infection Prevention Policy (IP162-66) Hand Hygiene. Beginning 09/27/2018 and ending 10/21/2018, the DON in-serviced all	

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F 880	Continued From page 24 asked if handling pills with gloved hands which had opened/closed medication cart drawers, touched her face and flipped her hair was good infection control technique. She stated, "No." On 09/26/18 at 8:15 AM, the above findings regarding medication set up for Resident #2 were reviewed with RN #2. She was asked if handling pills with gloved hands which had opened/closed medication cart drawers was good infection control practice. She stated, "No."	F 880	Jefferson Inn Licensed Nurses on Hand Hygiene and Medication Administration. Beginning 10/08/2018, the DON will conduct Medication Administration Observation weekly for four (4) weeks, then every two (2) weeks for four (4) weeks on A Shift (7A.M.-3:30P.M.), B Shift(3P.M.-11:30P.M.), and C Shift(11P.M.-7:30P.M.) to verify for proper hand hygiene, before during and after medication administration. The findings for each observation will be documented on the Medication Administration Observation form. Issues noted on the observation will be corrected by the DON promptly. All Newly hired nurses will be observed for competency for Medication Administration during building orientation. Any deficiencies will be reported to the Nursing Home Administrator for corrective actions. D. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance will be put into place? The DON will report findings to the Jefferson Inn Nursing Home Administrator (NHA) weekly. The NHA will report to the Jaquith Nursing Home (JNH) monthly Executive Committee Meeting and the quarterly JNH Quality Assurance Performance Improvement (QAPI) Committee meeting the progress and effectiveness of the corrected actions. Should systemic changes not be effective QAPI will investigate and determine	

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F 880	Continued From page 25	F 880	further action(s) to be implemented. The corrective action will be completed on November 16, 2018.	

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	25A402	A. BUILDING **01 - BUILDINGS 29 AND 33** B. WING _____	**09/28/2018**

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000		

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

Electronically Signed | 10/29/2018

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.

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E 000	Initial Comments *EMERGENCY PREPAREDNESS* Survey conducted on 9/28/18 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were identified.	E 000		

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