STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A403	A. BUILDING _____ B. WING _____	04/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JNH-ADAMS INN	3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 & 48 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 at the facility from 4/12/2016 to 4/15/2016. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation. The SA cited the following regulatory deficiencies: F253, F280, F315, and F514. At the time of survey, the census was 81, and the facility held a license for 133 beds.	F 000	Received 6/7/16 Reviewed 6/13/16 Approved 6/13/16 J Holloway	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review, the facility failed to maintain a clean and homelike environment as evidenced by a black substance on upper window sills, and stained and missing privacy curtains for 16 of 72 resident rooms, and two (2) of 2 buildings. Findings Include: Review of facility policy titled, "Cubical Curtains", dated May 2013, revealed that cubical curtains should be checked to identify those that need cleaning. The policy did not address who was to inspect and how often.	F 253	**A.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** On B31, Adams Inn Housekeeping staff began removing the black circular areas on 4/13/16 and was completed by 04/27/16 for the windowsills of rooms 113 (near bed D), 118 (on the upper portion of the windowsills near bed A and B), 119 (on the windowsill between beds B/C/D), and the Men's Dayroom (on the upper windowsills on the west side wall and the east side wall). On 4/15/16, the missing window curtain rod and panel over bed B were put up on in room 113. On 4/27/16, the brown and black stains on the wall above the windowsill were cleaned in room 118. On 5/18/16, Mississippi State Hospital's (MSH) Maintenance checked the light fixtures for damages/repairs in Room 118. On 4/15/16, the missing window curtain was put up in room 125. On 4/14/16, privacy curtains were cleaned or replaced in rooms 125 (bed A), 127 (beds A	6/13/16

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

Dawn Adams | HHA | 6/7/16

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 253 Continued From page 1

Review of facility policy titled, "Mold Prevention and Remediation", dated May 2013, revealed under #11 that hard surfaces should be damp wiped with water and mild detergent and allowed to dry, scrubbed if necessary. It read that the heat should be turned up and dehumidifiers used to dry the area.

Observation 04/12/16 from 9:50 AM through 11:32 AM with Registered Nurse (RN) #7 revealed the following:
Building 31:
In Room 113 near bed D, an upper window sill had a heavy pattern of black circular area, smooth in appearance covering the entire surface. The window over bed B had two approximately six (6) inch sections of curtain rod missing with a curtain panel missing.

Room 118 had brown and black stains on wall above the window sill, which appeared to radiate out from a light fixture . These stains cover an area approximately 1.5 (one and one half) feet long and 1 (one) foot wide. The window frames near beds A and B contained heavy rust on the metal frames around perimeter and on the areas separating window frames. The upper portion of the window sill contained black circular area, smooth in appearance covering entire surface.

Above and between beds B, C, and D in Room #119 had black circular area, smooth in appearance covering entire surface of the upper window sill.

Room 125 had a missing window curtain above bed A. The entire privacy curtain for bed A had yellow and black colored stains that were too numerous to count.

F 253

and D), 142, 143, and 145. On 5/10/16, window frames with rust were scraped and painted in room 118 (beds A and B). On 5/24/16, the three areas of the East Hall leading to the Men's Dayroom were plastered and painted. On B48, the crack in the wall in room 108 and the upside down L shaped crack in the wall in room 213 were plastered and painted on 5/31/16.

B. **How will you identify other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken?**
Beginning 4/15/16, The Adams Inn Housekeeping staff will use the Adams Inn Bedroom and Walls Checklist sheet to identify window curtains, privacy curtains, walls, and window frames that need painting, cleaning, replaced or repaired. Adams Inn's Coordinator of Unit Operation (CUO) will use the Building Environmental Checklist sheet to conduct weekly environmental rounds to ensure a safe, clean, comfortable and homelike environment exist for the residents of Adams Inn. The Adams Inn CUO will send a work order request for any deficiencies to Mississippi State Hospital's (MSH) Maintenance Department for painting and repairing.
C. What measures will be put into place, or what systemic changes you will put into place or make to ensure that the deficient practice does not recur?
Beginning 4/14/16, Adams Inn's Nursing Home Administrator (NHA) and CUO started inservicing Adams Inn's Housekeeping staff on the following policies: MSH Environmental Service's (ES) Hallways (Daily)- ES 191-30 ATT E; Walls, ES 191-30 ATT GGG;

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F 253	Continued From page 2 Room 127 had privacy curtains for bed A and D containing black stains that were too numerous to count over the entire curtain panels. The East Hall leading to the Men's Dayroom had three areas measuring approximately four (4) to 12 inches long and four (4) to six (6) inches wide of paint and plaster flaking off of the walls. The Men's Dayroom windows on the east and west wall had a heavy pattern of black circular areas that were smooth in appearance covering the entire surface of the upper six (6) window sills on west side wall and upper two (2) window sills on the east side wall. Room 142, Room 143, Room 145, and Room 148 had beige stains on the residents' privacy curtains that were too numerous to count. Observation 04/12/16 from 9:35 AM through 11:15 AM with Registered Nurse (RN) #8 revealed the following: Building 48: Room 108 had cracked plaster and flaking paint an area approximately one (1) foot by 1 foot on the wall above the wardrobe and adjacent to the window. Room 213 had a crack shaped like an upside down "L" about three (3) feet high and (4) foot to the left on the wall behind the bed and the left side of the window adjacent to the left side of the window. Environmental tour observation and interview with Housekeeping/Maintenance (H/M) Staff #1 on 04/15/16 at 2:45 PM and again at 4:00 PM on	F 253	Patient's Rooms, ES 191-30 ATT L; Window Glass – Interior, ES 191-30 ATT N; Internal and External Treatments. ES 191-7 ATT B; Dusting, ES 191-30 ATT C: Cubical Curtains. ES 191-30 ATT W; Lobbies, ES 191-30 ATT I; Rust Removal 191-30 ATT AAA; and Mold Prevention and Remediation, 191-31. This inservice ended on 4/27/16. New housekeeping staff will be inserviced when they arrive on the unit. On 4/15/16, the housekeeping staff started using the Adams Inn Bedroom and Walls Checklist sheet daily to identify window curtains, privacy curtains, walls, window sills and windows frames that need painting, cleaning, replaced or repaired. Starting 4/22/16, the Adams Inn CUO will conduct two random checks weekly from 7 am to 3:30 pm and 11:00 am to 6:30 pm to ensure that Adams Inn Housekeeping staff is properly performing cleaning tasks and completing the Adams Inn Bedroom and Walls Checklist sheet. After 90 days, Adams CUO will conduct weekly checks for completion of the Adams Inn Bedroom and Walls Checklist sheet. A binder with the Adams Inn Bedroom and Walls Checklist sheets will be located in the Adams Inn's CUO's office on B31. **D. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** Beginning 4/30/16, the Adams Inn CUO will report any deficiencies to the Adams Inn's NHA. The Adams Inn NHA will report the effectiveness of the systemic changes to the quarterly JNH Quality Assurance Performance	

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F 253	Continued From page 3 04/15/16 revealed H/M Staff #1 confirmed the black substance on the window sills and stated the black was mold. She said this was due to the old brick and concrete walls sweat a lot (condensation). She stated she had some of her staff working on it that day. H/M Staff #1 said she had four (4) housekeeping staff to clean Building #31 which is a 12,000 square foot building. That's two housekeeping staff with 12 rooms each plus the halls, showers and dayrooms. During this interview, H/M Staff #1 confirmed that the curtains were in need of cleaning and some needed to be replaced. She stated that taking down curtains required the use of a ladder and most women do not like to climb on a ladder. H/M Staff #1 stated, "If you're taking down curtains, you're not cleaning bathrooms, showers, halls, dining area and resident's rooms." She said she does weekly rounds looking in corners and at floors and had asked housekeeping supervisors from other buildings to come by and inspect. She revealed she had secured 24 new privacy curtains for Building 31 and was supposed to be receiving some more but did not know what had happened to them because she never received them. She revealed that she retrieved some window curtains and some rod sections from an old building but that was not enough. She confirmed that the windows have been measured and a bid has been submitted but it was denied and was a while ago. During an interview on 04/15/16 at 5:30 PM, the Administrator said he has turned in a work order for the window and privacy curtains. The Administrator stated the windows have been measured, and the facility is negotiating a contract to get the curtains made and replaced and that privacy curtains are included in this. It	F 253	Improvement (QAPI) committee. Should systemic changes not be effective the QAPI committee will investigate and determine further corrective actions to be implemented.	

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F 253	Continued From page 4 has been bid out. He also said he makes follow up environmental rounds in his buildings. Review of the facility's documentation revealed an email dated 4/18/16, with request and a list of quotes for drapes and valance totaling $47,761.60 for Building 31 and $15,380.01 for Building 48. The facility did not provide evidence of the actual purchase of these curtains.	F 253		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and facility policy review the facility failed to revise	F 280	**a. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** On 4/15/16, Resident # 8 care plan was corrected to reflect the accurate doses of Klonopin and non-continuation of Ambien. On 4/15/16, the Adams Inn MDS nurse reviewed and updated all of the care plans for residents of Adams Inn. **b. How will you identify other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken:** Beginning 4/15/16 when a new order is written, Adams Inn Registered Nurse and Licensed Practical Nurses will reconcile the order using the Medication Reconciliation Checklist. The MDS nurse will check the Medication Reconciliation Checklist weekly to ensure that orders are updated on the residents care plan. Also, the MDS nurse will complete the Adams Inn Care Plan Checklist weekly to ensure that care plans are updated. Discrepancies with physicians orders will be reported to the Adams Inn's physicians for further instructions.	6/13/16

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F 280	Continued From page 5	F 280		

Resident #8's care plan when the physician increased the resident's Klonopin dosage and no longer ordered Ambien for one (1) of 17 records reviewed.

Findings include:

Review of the facility's policy entitled "Nursing Documentation", dated December 2014, revealed care plans should be updated with all medication changes.

Review of Risk for Side Effects related to Psych Meds (psychiatric medications) care plan, dated 3/31/16, for Resident #8 revealed the care plan listed Ambien 10 milligram (mg) and Klonopin 0.5 mg as routine medications.

Review of Resident #8's physician's orders revealed an order, dated 3/15/16, increasing Klonopin to one (1) mg every hour of sleep (HS) and readmit orders, dated 2/19/16, with no physician's order for continuing Ambien.

Review of the Medication Administration Record (MAR), dated 4/16, revealed Klonopin one (1) mg, one (1) tablet per oral route (PO) at bedtime for 28 days. The MAR did not list Ambien as an active medication.

During an interview on 4/15/16 at 2:40 PM, Registered Nurse (RN) #5 stated care plans are updated quarterly and as needed. RN #5 confirmed she missed updating the care plans to include the medication changes on Resident #8.

Review of the facility's face sheet revealed the facility admitted Resident #8 on 11/13/08 with the diagnoses of Psychosis Not Otherwise Specified,

c. What measures will be put into place, or what systemic changes will you put into place or make to ensure that the deficient practice does not recur:
On 4/15/16, the Adams Inn Minimum Data Set (MDS) nurse, RN, and LPN were inserviced by Adams Inn's Director of Nursing DON on policy 210-016 Transcribing/Noting Physician Orders concerning accurate transcription of physician orders. The inserviced ended 4/20/16. New nurses will be inserviced once they arrive on the unit. Beginning 5/16/16, Adams Inn MDS RN will submit the Adams Inn Care Plan Checklist to the Adams Inn (DON) every Thursday for 90 days and monthly afterward. Adams Inn's Head Nurses (HN) will check the Medication Reconciliation Checklist for accuracy three times weekly for 90 days and monthly afterward. The Adams Inn DON will review the Adams Inn Care Plan Checklist and the Medication Reconciliation Checklist once weekly for accuracy for 90 days and monthly afterward.
d. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.
Beginning 5/16/16, the Adams Inn's DON will report any deficiencies or non-compliance to the Adams Inn Nursing Home Administrator. The Adams Inn NHA will report the effectiveness of the systemic changes to the quarterly JNH Quality Assurance Performance Improvement (QAPI) committee. Should systemic changes not be

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F 280	Continued From page 6 Moderate Mental Retardation, Hypothyroidism, and Degenerative Joint Disease. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/21/16 revealed a Brief Interview of Mental Status (BIMS) was conducted with a score of nine (9), indicating this resident had moderate cognitive impairment.	F 280	effective the QAPI committee will investigate and determine further corrective actions to be implemented.	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation record review, staff interview, and facility statement, the facility failed to secure foley catheter to prevent possible injury to the Resident #2's urethra and/or bladder for one (1) of 1 foley catheters observed out of a total of one catheter in the facility and failed to provide incontinent care to prevent possible infection as evidenced by wiping back to front during incontinent care for Resident #3. Findings Include:	F 315	**A. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** On 4/15/16, Resident #2's Foley catheter was secured with adhesive tape to her upper thigh to prevent injury or dislodgement. On 4/15/16, the Adams Inn Director of Nurses (DON) inserviced Adams Inn's Certified Nursing Assistants (CNAs), Registered Nurses (RN), and Licensed Practical Nurses (LPN) on Policy #162-117 Incontinence/Perineal Care and on Lippincott's Nursing Procedure 7th edition Pages 392-393 to ensure the securing of Foley Catheter. **B.How will you identify other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken?** Beginning 4/18/16, Adams Inn CNAs will be required to pass the Adams Inn's Foley Catheter Care Competency Test and complete the Adams Inn's Incontinent Care Competency Checklist that will be administered by Adams Inn's Head Nurses (HN) or DON. Any failures will be scheduled for additional training with Mississippi State Hospital Staff Education Department.	6/13/16

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F 315	Continued From page 7 Resident #2 Review of Lippincott's Nursing Procedures Sixth Edition revealed adhesive tape or leg band is used to secure the catheter to the patient's thigh or abdomen. Pulling on the catheter can injure the urethra and bladder wall. Observation on 4/13/2016 at 11:55 AM during foley care with Certified Nurses Assistant (CNA) #1 and CNA #2 revealed Resident #2's foley tubing pulled when CNA #1 and CNA #2 pulled resident up in bed. There was no leg strap or device to secure foley catheter in place to prevent pulling of the tube. During a care observation on 4/14/2016 at 11:00 AM with Registered Nurse (RN) #3 and Licensed Practical Nurse (LPN) #1 it was noted Resident #2 without leg strap or device to secure foley catheter tubing during care. Observation revealed foley tubing pulled during repositioning of resident during and after wound care. On 4/14/2016 at 11:00 AM, an interview with RN #3 revealed, "We don't have leg straps for the foley catheter, and they don't come in our foley catheter kits." An interview with LPN #1 on 4/14/2016 at 11:00 AM revealed, "We just try to be careful not to allow the foley tubing to be pulled when Resident #2 is repositioned since the resident does not have a foley leg strap." On 4/15/2016 at 11:45 AM, an interview with the Nurse Supervisor revealed, "We don't have leg straps facility wide; the leg straps don't come in our foley catheter kits. The Nurse Supervisor	F 315	changes to the quarterly JNH Quality Assurance Performance Improvement (QAPI) committee. Should systemic changes not be effective the QAPI committee will investigate and determine further corrective actions to be implemented. **C. What measures will be put into place, or what systemic changes you will put into place or make to ensure that the deficient practice does not recur?** Beginning 4/13/16, Adams Inn's CNAs will provide incontinent care by wiping from front to back as described in Policy #162-117 Incontinence/Perineal Care. Also, Adams Inn's CNAs will secure Foley catheters to the upper thigh with adhesive tape as described in Lippincott's Nursing Procedure 7th edition, page 393. These procedures will be ongoing. The Adams Inn's Foley Catheter Care Competency Test and the Adams Inn's Incontinent Care Competency Checklist will be used to verify that Adams Inn's CNAs are doing incontinent care and securing Foley catheters at a competent level. Adams Inn CNA supervisors or HN will observe the care of two residents three times a week to ensure the correct cleansing of perineal area from front to back during incontinent care. Adams Inn CNA supervisors or HN will observe foley catheter care for one resident three times a week to ensure the securement of the catheter. This will be ongoing Beginning 4/18/16 data from observation of securement of Foley catheters and the performance of incontinent care will be checked for completeness by Adams Inn DON for 90 days and then monthly.	

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F 315	Continued From page 8 also said Lippincott Nursing Guide is referenced for foley catheter care. She admitted the reference guide is not followed after she read the Lippincot Nursing Guide which revealed using adhesive tape or leg band to secure the catheter to the patient's thigh or abdomen. After requesting a facility policy, the facility provided a statement, dated 4/15/2016 and signed by the Nursing Home Administrator (NHA), that read that the facility did not have a foley catheter care policy. Review of the facility's face sheet revealed the facility admitted Resident #2 on 3/31/2015 with diagnoses of End Stage Dementia and Urinary Incontinence. Review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD)of 3/07/2016 revealed, Resident #2 had a Brief Interview of Mental Status (BIMS) score of "Blank" indicating the Resident #2 has severe cognitive impairment. Resident #3 Review of facility's policy titled, "Incontinent/Perineal Care", dated July 2014 revealed Nursing or Certified Nursing Assistance (CNA) will provide incontinence/perineal care... working outward to the surrounding perineum from front to back to the area of greatest soiling." During an incontinent care observation on 04/13/16 at 11:15 AM, Certified Nursing Assistant (CNA) #3 wiped Resident #3's Perineal area from the rectal area towards the vaginal area.	F 315	**D. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Beginning 4/18/16, the Adams Inn's DON will report any deficiencies or non-compliance to the Adams Inn Nursing Home Administrator . The Adams Inn NHA will report the effectiveness of the systemic changes to the quarterly JNH Quality Assurance Performance Improvement (QAPI) committee. Should systemic changes not be effective the QAPI committee will investigate and determine further corrective actions to be implemented.	

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JNH-ADAMS INN	3850 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 & 48 WHITFIELD, MS 39193

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F 315	Continued From page 9 During an interview on 04/15/16 at 11:30 AM, CNA #3 confirmed that she had cleaned from back to front. She revealed that she thought she had cleaned from back to front, but she might have not. She was not sure. She stated that she was supposed to clean from front to back to avoid infections. During an interview on 04/15/15 at 12:05 PM, Registered Nurse (RN) #1, the Unit Nurse Manager, stated that the CNAs should wipe front to back and if the CNA wiped the opposite direction, it could cause a Urinary Tract Infection. During an interview on 04/15/15 at 12:15 AM, RN #6 revealed CNAs were trained on the proper direction of cleaning during orientation and periodic competencies. Cleaning the wrong direction could cause a Urinary Tract infection. The facility admitted Resident #3 on 11/29/12 with diagnoses including Dementia and Dysphagia.	F 315		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	F 514	**A. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** On 4/14/16, the correct diet order was verified and corrected by the Clinical Nutritional Specialist and Adams Inn B48 Pantry Coordinator. Unsampled Resident A was issued the correct pureed diet. On 4/15/16, Resident #8's medical records were corrected to reflect the accurate doses of Klonopin and Levothyroxin. And Bisacodyl was changed to its correct form. **B. How will you identify other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken?**	6/13/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A403	A. BUILDING _____ B. WING _____	04/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JNH-ADAMS INN	3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 & 48 WHITFIELD, MS 39193

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F 514	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review the facility failed to ensure the diet list from the Dietary department matched the physician's order and resident's care plan for one (1) of 14 resident diet orders reviewed for Unsampled Resident A and failed to ensure complete physician's orders related to medication dosage for one (1) of 17 records reviewed for Resident #8. Findings included: Review of the facility's policy titled, "Transcribing/Noting Physician's Orders", dated January 2016, revealed the nurse signing off orders accepts responsibility for ensuring those orders were transcribed correctly. Review of the facility's policy titled, "24 Hour Chart Checks", dated July 2014, revealed orders written in the last 24 hours are checked to ensure all physician's orders have been signed off and transcribed correctly. Record review of the facility's policy related to diet orders, dated February 2016, revealed any changes to resident diet orders will be made by the physician or nurse practitioner and recorded on the physician's order sheet. The food service diet clerk will clarify any questionable diet orders with the nurse. Any changes to the diet will be called in to the diet office of the food service department by the nurse signing off the	F 514	On 4/14/16, to ensure the diet list from the dietary department matches the physician's order and resident's care plan, Adams Inn Pantry Staff and Registered Nurses (RN) will complete the Adams Inn's Dietary Order Check List weekly and PRN. Adams Inn's RNs will report any deficiencies to the Clinical Nutritional Specialist for corrections. Beginning 4/15/16 when a new order is written, Adams Inn Registered Nurse (RN) or Licensed Practical Nurse (LPN) will reconcile the order by using Adams Inn's Medication Reconciliation Checklist. Any discrepancies will be reported to the Adams Inn's physicians for further instructions. **C. What measures will be put into place, or what systemic changes you will put into place or make to ensure that the deficient practice does not recur?** Beginning 4/14/16 and ending 4/20/16, Adams Inn's Director of Nursing (DON) inserviced Adams Inn's Pantry Staff, RNs, and LPNs on Policy 210-76 Diet Order and Diet Changes and Policy 210-016 Transcribing/Noting Physician's Orders, and policy 210-010 24 hour Chart Check. New hires will be inserviced once that arrive on the unit. RNs and LPNs will transcribe diets orders as specified by policy 210-76 Dietary Orders and Diet Changes and policy 210-016 transcribing/Noting Physicians Orders. Adams Inn's Pantry Staff will serve the correct diet as ordered per physician. Once weekly or PRN, Adams Inn's RNs and Panty Staff will check residents' diet lists for accuracy using the Adams Inn Dietary Order Check List. The Head Nurses (HNs) will check Adams Inn Dietary Order Check List	

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	25A403	A. BUILDING _____ B. WING _____	04/15/2016

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JNH-ADAMS INN	3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 & 48 WHITFIELD, MS 39193

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F 514	Continued From page 11 physician's order. The diet list will be updated by the nurse, and sent to the dietary department's pantry staff on that building. Tray service is communicated to the food and nutrition service department by the residents building staff. Unsampled Resident A Observation and interview on 4/14/2016 at 12:58 PM of the tray line procedure and meal service revealed Dietary Staff #1 and Clinical Nutritional Specialist having an inaudible discussion. Clinical Nutritional Specialist left the pantry and went to the nurses station. The surveyor followed and questioned Clinical Nutritional Specialist as to why she left the pantry. The Clinical Nutritional Specialist explained she was checking the diet slip against Unsampled Resident A's physician orders. Interview with Dietary Staff #1 on 4/14/16 at 1:35 PM revealed, "I noticed when I was getting food temps during lunch that (Unsampled Resident A) did not receive her pureed diet tray from the kitchen. I knew she was on a pureed diet, but they didn't send her one. I called and requested a pureed diet for her before we started getting food temperatures. I mentioned it to the Clinical Nutritional Specialist and that's when she went to check the resident's MD order." Record review of Unsampled Resident A's physician's orders revealed on 3/21/2016, the physician ordered to change the resident's diet to a pureed diet, and consult speech. An order	F 514	and observe one meal weekly to ensure the residents' diet lists are properly followed. Use of the Adams Inn Dietary Order Check List will be on going for RNs and Pantry Staff. After 90 days, the HNs will check the Adams Inn Dietary Order Check List monthly The HNs will report any deficiencies to the Adams Inn DON. On 4/18/16, the Adams Inn Director of Nurses (DON) began inservice with the Adams Inns Registered Nurses (RN) and Licensed Practical Nurses (LPN) on policy 210-016 Transcribing/Noting Physician Orders and policy 210-010 24-hour Chart The inservice ended 4/25/16. New RNs and LPNs will be inserviced once they arrive on the unit. As physician orders are written, Adams RNs and LPNs will use Adams Inn's Medication Reconciliation Checklist to ensure physician orders are transcribed correctly. Adams Inn's Head Nurses (HN) will check the Adams Inn's Medication Reconciliation Checklist for accuracy three times weekly for 90 days, and weekly after 90 days. Adams Inn's DON will check weekly for deficiencies for 90 days, and monthly after 90 days. A binder containing the Adams Inn Medical Reconciliation Checklist will be located in the HN office. **D. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** Beginning 4/15/16, the Adams Inn's DON will report any deficiencies or non-compliance to the Adams Inn NHA. The Adams Inn NHA will report the effectiveness of the systemic changes to the quarterly JNH Quality Assurance Performance Improvement (QAPI)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A403	A. BUILDING _____ B. WING _____	04/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JNH-ADAMS INN	3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 & 48 WHITFIELD, MS 39193

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F 514	Continued From page 12 dated 3/22/2016 revealed speech therapy 5 times a week for 2 weeks to address, "Mild oral-pharyngeal dysphagia, determine safest diet texture and liquids consistency, develop and train compensatory swallow strategies and provide nursing staff education." Review of the "Nurses Notes" revealed a note dated 3/21/2016 at 9:45 AM that read, "Diet changed to pureed diet. Speech consult per Bld (building) Dr (doctor's name) to evaluate swallowing." Record review revealed an order dated 3/25/2016 to discharge from ST (speech therapy) services, receiving pureed diet with thin liquids. Cue staff to position tray to left visual field." Review of the "Nutritional Status Change" form dated 3/21/2016 revealed the form was completed and signed by the Director of Nurses (DON) and Pantry Staff #1, changing the type of diet to pureed. Review of Unsampled Resident A's lunch diet slip for 4/14/2016 revealed, ¾ cup of baked spaghetti, ½ cup of sliced carrots, ½ pear, one (1) yellow cake cupcake, 1 dinner roll, and 1 cup of iced tea. The diet slip identified the resident's diet as entree chopped, low fat. Record review of the facility's diet list dated from February 29, 2016 through April 17, 2016, revealed the diet listed as low fat diet with	F 514	committee. Should systemic changes not be effective the QAPI committee will investigate and determine further corrective actions to be implemented.	

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	25A403	A. BUILDING _____ B. WING _____	04/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JNH-ADAMS INN	3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 & 48 WHITFIELD, MS 39193

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F 514	Continued From page 13	F 514		

chopped entrée, no crackers, bread, cornbread, cookies, cakes, or diced ham.

Interview on 4/14/2016 at 1:00 PM with Licensed Practical Nurse (LPN) #3 revealed Unsampled Resident A had been receiving a pureed diet and had a pureed diet tray delivered for breakfast on 4/14/2016. LPN #3 explained the process for transcribing diet orders was placing a copy of diet change sheet in the dietician's box, place a copy of nutritional status change sheet in the Nutritional Status Change Book and give a copy to the pantry worker. The nurse also called the dietary department to report any diet changes.

During an interview on 4/14/2016 at 1:12 PM, the Director of Nursing (DON) stated, "I took off the diet order on 3/21/2016," for Unsampled Resident A. The DON said she placed the new pureed diet order on the nutritional diet sheet and placed it in the Nutritional Status Change Book, phoned dietary department with the new diet order, informed Dietary Pantry Staff #1, and had her to co-sign the diet change sheet to verify knowledge of Unsampled Resident A's change in diet. She said the process was for a nurse to verify the diet list against the physician's orders at the end of each month. The DON confirmed Unsampled Resident A's diet slip for lunch on 4/14/2016 and the Nutritional Diet List for April 11, 2016 - April 17, 2016 did not coincide with the resident's prescribed diet ordered by the physician. The DON was unable to give a reason for the inconsistencies between the diet order and Nutritional Diet List and the resident's main dietary department diet slip. The DON said she could understand how being served the incorrect

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	25A403	A. BUILDING _____ B. WING _____	04/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JNH-ADAMS INN	3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 & 48 WHITFIELD, MS 39193

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F 514	Continued From page 14	F 514		

diet could pose harm to the resident because Unsampled Resident A has swallowing problems.

On 4/14/2016 at 1:25 PM, an interview with the Clinical Nutritionist Supervisor revealed she was unable to explain why Unsampled Resident A's Nutritional Diet List, the resident's diet slip, and the resident's food delivered from the main dietary department were different from the physician's order for a pureed diet, dated 3/21/2016. She said diet changes are made only when the nurse from the resident's building notifies the main dietary department of a change in diet. Clinical Nutritionist Supervisor said once each quarter the registered dietician assigned to the building will check the physician's diet order against the diet sheets.

Review of the last quarterly "Patient Diet Review" provided 4/15/16 by the Clinical Nutritionist Supervisor was dated 3/3/16, prior to the order change for Unsampled Resident A. Documentation on this review revealed a "yes" checked under "Diet List Match Order".

Interview on 4/15/2016 at 10:00 AM with Clinical Nutritionist Supervisor revealed the facility receives the resident's diet list weekly for each building.

Review of the facility's Face Sheet revealed, the facility admitted the resident on 12/01/2008. Un-sampled Resident A's diagnoses included Schizoaffective Disorder, Anemia, and Chronic Pancreatitis.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A403	A. BUILDING _____ B. WING _____	04/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JNH-ADAMS INN	3560 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 & 48 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 514	Continued From page 15	F 514		

Review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/11/2016 revealed Unsampled Resident A's Brief Interview for Mental Status (BIMS) score was not completed due to Un-sampled Resident A having severe cognitive impairment. The MDS indicated under Section G that the resident was independent in feeding with set up help needed.

Resident #8

Review of Resident #8's readmit orders dated 2/19/16 revealed an order for Klonopin with no strength. The order for Klonopin read, "Klonopin tablet (1)" to be given every night. Resident #8's readmit orders, dated 2/19/16, contained an order for Levothyroxine 125 milligrams (mg), instead of 125 micrograms (mcg), and an order for Bisacodyl 10 mg to be administered per rectum with no medication form specified.

During an interview on 4/15/16 at 9:40 AM, the Director of Nursing (DON) confirmed the deficient practice of inaccurate physician's orders for Resident #8. The DON stated clarification orders should have been written to correct the errors but none were done. The DON explained when a resident is readmitted the physician is called so that the resident's medications can be verified and orders received as to whether or not to continue, discontinue, or change the orders.

Review of the facility's face sheet revealed the facility admitted Resident #8 on 11/13/08 with the diagnoses of Psychosis, Moderate Mental Retardation, and Degenerative Joint Disease.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A403	A. BUILDING _____ B. WING _____	04/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JNH-ADAMS INN	3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 & 48 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 514	Continued From page 16	F 514		

Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/21/16 revealed a Brief Interview of Mental Status (BIMS) was conducted with a score of nine (9), indicating this resident had moderate cognitive impairment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A403	A. BUILDING 48 - BUILDING 48 B. WING _____	05/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility meets the applicable provisions of the 2000 (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

David Sanders | NHA | 6/25/15

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.

David Sanders | NHA | 6/30/15