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 _____	06/28/2017

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 Survey Agency (SA) conducted an annual recertification survey from 06/26/17 through 6/28/17. During the survey, the SA determined the facility was not in compliance with the Centers for Medicare and Medicaid Services Conditions of Participation. The SA cited deficiencies at F278. The facility is licensed for 86 beds and the census at the time of survey was 78.	F 000		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each	F 278		8/18/17

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

Electronically Signed | 08/10/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 278	Continued From page 1 assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and facility statement, the facility failed to accurately code the Minimum Data Set (MDS) assessment for two (2) of 16 resident records reviewed; Resident #10 and #15. Findings Include: Review of the facility's statement dated 06/28/17, and signed by the Administrator, revealed the facility "has no specific policy on Minimum Data Set (MDS) Assessment and Care Plans." A review of the CMS 3.0 Manual, dated October 2015, under Functional Status (Section G), revealed coding instructions for each Activity of Daily Living (ADL) activity to consider all episodes of activity that occur over a 24 hour period during each day of the seven (7) day look back period. "The responsibility of the person completing the assessment, therefore, it to capture the total picture of the resident's ADL self performance over the 7 day period, 24 hours a day (i.e., not only how the evaluating clinician sees the resident, but how the resident performs on other shifts as well). Resident #10	F 278	A. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? On 08/02/17, resident #10's Minimum Data Set (MDS) was updated by Adams Inn MDS Nurse to reflect the proper coding of ADLs related to transfers. On 08/02/17, resident #15's MDS was updated by Adams Inn's MDS Nurse to reflect the correct coding for discharge from Hospice care. B. How will you identify other residents having the potential to be affected by same deficient practice, and what corrective action will be taken? Seventy-eight residents of Adams Inn had the potential to be affected by this deficient practice. Beginning 06/29/17 through 08/02/2017, Adams Inn MDS nurse reviewed 78 residents care records for the deficient practice. No other residents were affected. Observations will be documented on the Adams Inn Coding Worksheet to ensure that MDS ADL	

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F 278	Continued From page 2 Observation on 6/26/17 at 10:48 AM, during initial tour, revealed Resident #10 was standing in the doorway to her room and then went and sat on her bed. Resident #10 rose from the bed into a standing position without assistance and ambulated out of her room. A review of the most recent quarterly MDS assessment with an Assessment Reference Date (ARD) of 05/01/17, for Resident #10, revealed ADL Assistance (Section G 110) was coded Transfer did not occur during the 7-day look back period. Balance and Transfer during Transitions and Walking (Section G300) was coded Surface to Surface transfer did not occur during the 7-day look back period. However, Resident #10 was checked for being independent with bed mobility, walking in room, walking in corridor, and locomotion on and off unit during the 7-day look back period. In order for these activities to have occurred, Resident #10 would have had to be able to transfer during the 7-day look back period. A comparison review of the annual MDS assessment with an ARD of 08/22/16, revealed G110 and G300 related to transfer was also coded as not occurring during the 7-day look back period. Review of the comprehensive care plan for Resident #10 revealed a problem to address ADLs that indicated Resident #10 was generally independent with ADLs requiring supervision only. Interview on 06/27/17 at 10:20 AM, with Registered Nurse (RN) #1, revealed upon review of the quarterly and annual MDS assessments for Resident #10, the coding of ADLs related to Transfers was "coded wrong."	F 278	assessments are coded correctly. Any deficiencies will be reported to the Adams Inn Director of Nursing (DON) Nurse for corrective actions. C. What measures will be put into place, or what systematic changes you will make to ensure that the deficient practice does not occur? On 08/02/17, Licensed Practical Nurses (LPNs) and Registered Nurses (RNs) were in-serviced by MDS Nurse and DON on how to properly code each resident's ADL's. The Adams Inn LPN and RN will write the level of ADL transfer of the resident on the Adams Inn Coding Worksheet. The Adams Inn MDS Nurse and Head Nurses will check the Adams Inn Coding Worksheet of (3)residents a week for a period of 90-days, and then one resident weekly thereafter. Any deficiencies will be reported to the Adams Inn 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? Beginning 08/07/17, Adams Inn DON will report any deficiencies of non-compliance to the Adams Inn Nursing Home Administrator. The Adams Inn NHA will report the deficiencies of the systemic changes to the quarterly JNH Quality Assurance Performance Improvement Committee (QAPI) and the monthly Jaquith Nursing Home Executive	

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F 278	Continued From page 3 During an interview on 6/27/17 at 3:35 PM, RN #1 stated she used the MDS 3.0 manual as reference for coding assessments. Review of the face sheet revealed the facility admitted Resident #10 on 09/16/15, with diagnoses which included Alcoholic Dementia with Behavioral Disturbance and Depression. A review of the quarterly MDS assessment with an ARD of 05/01/17, revealed Resident #10 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated severe cognitive impairment. Resident #15: Record review of Resident #15's September 2016 Physicians Orders, revealed Hospice services were discontinued on 09/14/16. Record review of Resident 15's MDS with an ARD of 05/01/17, revealed Resident #15 was marked in Section" O" (Special Treatments, Procedures and Programs) as a resident that had been on Hospice in the last 14 days. During an interview on 06/28/17 at 11:30 AM, the Director of Nursing (DON) confirmed the MDS was marked in section "O" as if Resident #15 was a Hospice Resident. The DON confirmed Resident #15 was discharged from Hospice on 09/14/16, therefore the MDS was coded incorrectly. During an interview on 06/28/16 at 12:10 PM, Registered Nurse (RN) #1 (MDS Nurse) confirmed the MDS was marked in section "O" as if Resident #15 was a Hospice Resident and was receiving Hospice care. RN #1 said she knew	F 278	Committee to determine further corrective actions to implement. Completion Date: 8/18/17	

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F 278	Continued From page 4 Resident #15 was discharged from Hospice. RN #1 said she was notified of changes to make on the MDS when she looked at physicians orders while reviewing the chart. RN #1 said she must have just forgotten to make the change to the MDS when Resident #15 was discontinued from Hospice. The facility admitted Resident #15 on 03/31/15, with diagnoses which included advanced Alzheimer's Dementia and Stage II Chronic Kidney Disease. Review of the MDS with an Assessment Reference Date (ARD) 5/1/17, revealed staff assessed Resident #15 who was unable to complete the BIMS Assessment due to severe cognitive impairment.	F 278		

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	25A403	A. BUILDING **48 - BUILDING 48** B. WING _____	**06/27/2017**

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K 000	INITIAL COMMENTS 42 CFR 438.70(a) The facility must meet the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA) ...	K 000		
K 222 SS=F	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler	K 222	FIRE SAFETY Received SEP 1 2017 MSDH-HFLC & CONSTRUCTION Ok pul 9-1-17 Accepted Per Tim (CMS) Revisit	8/18/17

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

Electronically Signed | 08/31/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 222	Continued From page 1 and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to properly maintain exit doors as per NFPA 101 section 19.2.2.5.2. This deficiency had the potential to affect all exits and all 78 residents in the facility on the day of survey. Findings include: On June 27, 2017 at 10:55 AM, observation and interview revealed the temporary staff (agency	K 222	A. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? On 6/27/17, all temporary staff (agency nurses) were provided keys to the exit doors of the facility. B. How will you identify other residents	

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	25A403	A. BUILDING **48 - BUILDING 48** B. WING _____	**06/27/2017**

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K 222	Continued From page 2 nurses) was not provided with keys to the locks on the exit doors of the facility. The Facility Administrator and Maintenance Director stated keys to the exits are not issued to temporary staff.	K 222	having the potential to be affected by same deficient practice, and what corrective action will be taken? Seventy-eight residents had the potential to be affected by this deficient practice. None were affected. Beginning 8/7/17, The Adams Inn Key and Fire Door Checklist and Key Log Binder will be used to ensure that temporary staff (agency nurses) are provided with keys to the locks on the exit doors of the facility. Deficiencies will be reported to Adams Inn's Coordinator of Operations (CUO) for corrective action(s). C. What measures will be put into place, or what systematic changes you will make to ensure that the deficient practice does not occur? On 6/27/17, Adams Inn's Nursing Home Administrator, CUO, and Director of Nursing begin inservicing Adams Inn's Nursing Staff, Pantry Staff, Certified Nursing Assistants (CNAs), Housekeeping Staff, Psychology staff, Laundry staff, Recreation staff, Social Worker, Staffing Coordinator, Medical Record staff, and Temporary (agency nurses and CNAs) on Policy JNH J-530-20 Fire Plan. Inservice will end 8/12/17. On 8/2/17, Mississippi State Hospital Fire Marshals inserviced Adams Inn staff on the facility Fire Safety policy. Beginning 8/7/17, Adams Inn Charge Nurses will used the Adams Inn Key and Fire Door Checklist to conduct one random key check each shift (A Shift-7 am to 3:30 pm, B-Shift 3 pm to	

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K 222	Continued From page 3	K 222	11:30 pm, C-Shift 11 pm to 7:30 am) per week for 90 days, and once a month afterwards. Any deficiencies will be reported immediately to Adams Inn CUO for corrective actions. If there are no deficiencies during the random check, the Adams Inns CUO will check the Adams Inn Key and Fire Door Checklist weekly for deficiencies. The Adams Inn Key and Fire Door Checklist will be located at the nurses station in the Key Log Binder. 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? Beginning 08/07/17, Adams Inn CUO will report any deficiencies to the Adams Inn Nursing Home Administrator. The Adams Inn NHA will report the deficiencies of the systemic changes to the quarterly JNH Quality Assurance Performance Improvement Committee (QAPI) and the monthly Jaquith Nursing Home Executive Committee to determine further corrective actions to implement. Completion Date: 8/18/17	
K 700 SS=F	NFPA 101 Operating Features - Other Operating Features - Other List in the REMARKS section any LSC Section 18.7 and 19.7 Operating Features requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in Form CMS-2567.	K 700		8/18/17

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K 700	Continued From page 4 This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to properly train the employees with respect to their duties under the evacuation, and relocation plan and fire drills as per NFPA 101 section 19.7.1.2. This deficiency affected all 78 residents in building 31 and 48 of the facility. Findings Include: On June 27, 2017 at 10:20 AM, observation and interview revealed the temporary staff (agency nurses) were not properly trained on the operation of the fire alarm system. The fire alarm system requires a key to operate the fire alarm pull stations, and no training record could be provided. Additionally, the temporary staff were not being provided a key to operate the manual pull stations of the fire alarm system. The facility is fully sprinkled and smoke detectors are installed in the building.	K 700	A. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? On 6/27/17, all temporary staff (agency nurses) were provided keys to the fire alarm system of the facility and inservices begin on the facility's fire safety policy. B. How will you identify other residents having the potential to be affected by same deficient practice, and what corrective action will be taken? Seventy-eight residents had the potential to be affected by this deficient practice. None were affected. Beginning 8/7/17, The Adams Inn Key and Fire Door Checklist and Key Log Binder will be used to ensure that temporary staff (agency nurses) are provided with keys and know how to activate the facility's fire alarm system. Deficiencies will be reported to Adams Inn Coordinator of Operations (CUO) for corrective action(s). C. What measures will be put into place, or what systematic changes you will make to ensure that the deficient practice does not occur? On 6/27/17, Adams Inn Nursing Home Administrator, CUO, and Director of Nursing begin inservicing Adams Inn's Nursing Staff, Pantry Staff, Certified Nursing Assistants (CNAs), Housekeeping Staff, Psychology staff, Laundry staff,	

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K 700	Continued From page 5	K 700	Recreation staff, Social Worker, Staffing Coordinator, Medical Record staff, and Temporary (agency nurses and CNAs) on Policy JNH J-530-20 Fire Plan. Inservice will end 8/18/17. On 8/2/17 Mississippi State Hospital Fire Marshals inserviced on the facility Fire Safety policy, activating the fire pull stations, and evacuation routes and locations. Beginning 8/7/17, Adams Inn's Charge Nurses will use the Adams Inn Key and Fire Door Checklist to conduct one random key check per shift per week for 90 days, and once a month afterwards. Any deficiencies will be reported immediately to Adams Inn CUO for corrective actions. If there are no deficiencies during the random check, the Adams Inn CUO will check the Adams Inn Key and Fire Door Checklist weekly for deficiencies. 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? Beginning 08/07/17, Adams Inn CUO will report any deficiencies of non-compliance to the Adams Inn Nursing Home Administrator. The Adams Inn NHA will report the deficiencies of the systemic changes to the quarterly JNH Quality Assurance Performance Improvement Committee (QAPI) and the monthly Jaquith Nursing Home Executive Committee to determine further corrective actions to implement. Completion Date: 8/18/17	

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