MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	61AI	A. BUILDING: _____ B. WING _____	03/31/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted an annual survey at the facility from 3/28/22 through 3/31/22. During the survey the SA determined the facility was not in compliance with Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm and cited M640.	M 000		
M 640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This Statute is not met as evidenced by: Based on observations and interviews, the facility failed to ensure smoking refuse was disposed of in a safe and sanitary manner for one (1) of two (2) smoking area observations. On 3/29/2022 at 4:45 PM, the SA observed Resident #17 smoking in the facility courtyard. When the resident finished smoking, he threw his cigarette onto the ground in a grassy area. Certified Nursing Assistant (CNA) #1 told Resident #17, "You can't throw that on the ground." Resident #17 retrieved the cigarette butt from the ground and placed it in a Styrofoam cup that had water in it. Resident #17 stated that they had been throwing the cigarettes butts on the ground and "why are we changing now". The SA observed a large amount of cigarette butts in the grass in the facility courtyard, which is the designated smoking area. On 3/29/2022 at 4:47 PM, an interview with	M 640	On 3/29/22, the Nursing Home Administrator and Nursing Home Administrator In -Training observed the facility courtyard and noted a large amount of cigarette butts in the grass. Appropriate interventions were put in place immediately for the safety of all the residents. The grass was raked and cleaned to remove the large amount of cigarette butts. Staff were instructed to no longer allow the two residents to smoke in the grassy area effective 3/29/22. On 3/29/22, the Director of Nursing, (DON) educated resident #17 and the other resident who smokes on safe smoking practices, new assigned smoking area, and use of placing cigarette butts in the proper smoking receptacle. Thirty-nine, (39) residents were identified	4/28/22

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M 640	Continued From page 1 Resident #17 revealed that he had always thrown his cigarette butts in the grass, and he had not been putting his cigarettes in a cup. On 3/29/2022 at 4:53 PM, during an interview with CNA #1, she confirmed Resident #17 threw the cigarette butt on the ground and that there was a large amount of cigarette butts in the grass in the courtyard. CNA #1 stated that when she takes the residents to smoke, she brings a Styrofoam cup with water for the residents to put the cigarettes butts in when they have finished smoking. She said she does not know what the other employees do when they are assisting residents with smoking. During an interview on 03/29/22 at 04:55 PM with the Administrator and the Administrator in Training (AIT), they observed and confirmed there was a large amount of cigarette butts in the grass in the courtyard. The Administrator said this could cause a fire by throwing lit cigarette butts in the grass. The Administrator said he did not know the residents were throwing the cigarette butts in the grass. Record review of the "Identification and Summary Sheet" revealed the facility admitted Resident #17 on 7/15/2005. Record review of the Quarterly Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 11/24/21 revealed Resident #17 had a Brief Interview of Mental Status (BIMS) of 03 which indicated Resident #17 is cognitively impaired.	M 640	as having a potential risk for the deficient practice. All staff was in-serviced by the Director of Nursing on Identifying and Mitigating Hazards and Risks in the Physical Environment of Patients/Residents and JNH Tobacco/Smokeless Tobacco and Electronic Cigarettes policy and procedure on 4/6/2022. Beginning 3/29/22 resident□s will be monitored for the duration of their assigned smoke breaks in a new assigned non-grassy smoking area by the assigned Certified Nursing Aide. New smoking receptacles were purchased by the facility on 4/13/2022, once received will be placed in the assigned smoking area no later than 4/22/22 for residents to dispose of their cigarette butts in a safe and sanitary manner. Beginning 3/30/22, resident□s will be monitored for the duration of a smoke break by the Nursing Home Administrator In -Training weekly for four weeks then monthly for two months to ensure the disposal of cigarette butts are placed in the proper receptacle. This will ensure that appropriate interventions are in place to reduce the risk of resident accidents. Beginning 4/27/22 the Nursing Home Administrator In -Training will report deficiencies noted during the smoking breaks to the Quality Assurance Performance Improvement (QAPI) Committee monthly for two months or until such time consistent substantial compliance has been achieved as	

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M 640	Continued From page 2	M 640	determined by the committee. Should systemic changes not be effective QAPI will investigate and determine further action(s) needed based on findings.	