STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A197	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) COMPLETION DATE
F 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 the requirements for participation in Medicare and Medicaid. The SA cited F636, F638, F641, and F689 during the survey. The facility held a license for 45 beds and had a census of 39 at the time of the survey.	F 000		
F 636 SS=E	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions.	F 636		4/28/22

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

Electronically Signed | 04/15/2022

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F 636	Continued From page 1 (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to complete the comprehensive Minimum Data Set (MDS) for two (2) of 26 residents reviewed for comprehensive	F 636	Resident #15 and Resident # 37□s comprehensive annual Minimum Data Set (MDS) was completed and submitted by Registered Nurse, (RN)	

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F 636	Continued From page 2 assessments, with the potential to affect 39 residents. Resident #15 and Resident #37. ` Findings Include: A record review of the facility's statement dated 3/31/2022 revealed, "(Proper Name of Facility) utilizes the RAI (Resident Assessment Instrument) for MDS (Minimum Data Set) guidance and submission." A record review of Centers for Medicare and Medicaid (CMS) RAI Version 3.0 Manual dated October 2019 revealed, "The Annual assessment is a comprehensive assessment for a resident that must be completed on an annual basis (at least every 366 days) ..." Resident #15 Record review of the "Identification and Summary Sheet" revealed the facility admitted Resident #15 on 2/6/2013. Record review of the last completed MDS revealed a quarterly assessment with an Assessment Reference Date (ARD) of 10/27/21. Further review of the medical record revealed Resident #15's comprehensive annual assessment had not been completed. Resident #37 Record review of the "Identification and Summary Sheet" revealed the facility admitted Resident #37 on 3/9/2020. Record review of the last completed MDS revealed a quarterly assessment with an ARD of	F 636	Minimum Data Set (MDS) nurse on 3/30/22. Thirty-nine (39) residents have the potential to be affected by the deficient practice On 3/29/22 the Nurse Administrator in-serviced the MDS nurse on MDS Assessment and submission procedure and using the resident assessment instrument (RAI) Version 3.0 manual specified by Centers for Medicare and Medicaid (CMS.) The MDS nurse was provided more training on 3/30/22 on coding the MDS accurately by RN #3 MDS nurse. The MDS nurse will attend a MDS training workshop for extensive training on 4/28/22 offered by the State Agency. The facility created a Minimum Data Set Assessment policy and procedure that was reviewed and approved in the JNH Executive meeting on 4/14/22 and will be presented and approved by the Clinical Policy Committee by 4/28/2022. The Director of Nursing will review the MDS schedule beginning 3/30/22 and verify the MDS nurse has completed the MDS prior to submission weekly for two months then monthly for one month. Beginning 3/30/22 the Nurse Administrator will monitor the final Validation Reports weekly for one month then monthly thereafter. Beginning 3/30/22 the Nurse Administrator will report any MDS	

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F 636	Continued From page 3 11/3/21. Further review of the medical record revealed Resident #37's comprehensive annual assessment had not been completed. On 03/29/22 at 11:04 AM, in an interview with Registered Nurse #2 (RN)/MDS Nurse, she stated that the MDS assessments are not up to date because she took the position approximately three months ago and received training for one and a half (1 ½) weeks. After training, she was working on her own and it takes her longer to complete the MDS assessments. She confirmed that she is behind on completing assessments and she knows it is important for MDS assessments to be completed in a timely manner. On 03/31/22 at 11:31 AM, in an interview with the Nursing Home Administrator (NHA)/ Nursing Home (NH) Director, he stated he was not aware the MDS assessments were not current, and he confirmed it is important for them to be up to date. The current MDS nurse took the position in October or November of 2021 and the Director of Nursing (DON) should check behind the MDS nurse. He stated the DON is also new in her position and she assumed the MDS nurse was completing assessments in a timely manner. On 03/31/22 at 10:30 AM, during an interview with the Nursing Administrator, she explained the facility does not have a MDS Policy and the facility used the RAI Manual for reference in completing MDS assessments and MDS submissions. She reported she was not aware the MDS nurse was behind on MDS assessments.	F 636	inaccuracies weekly to the Nursing Home Administrator who will then report to the Quality Assurance Performance Improvement (QAPI) Committee on 4/27/22, then monthly for two months to ensure substantial compliance has been met. Should systemic changes not be effective QAPI will investigate and determine further action(s) needed based on findings.	
F 638 SS=E	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c)	F 638		4/28/22

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F 638	Continued From page 4 §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to complete quarterly Minimum Data Set (MDS) Assessment for 17 of 26 residents reviewed for MDS assessments, with the potential to affect 39 residents. Resident #7, Resident #10, Resident #13, Resident #16, Resident #18, Resident #19, Resident #20, Resident #22, Resident #23, Resident #26, Resident #27, Resident #30, Resident #31, Resident #33, Resident #34, Resident #35 Resident #36 Findings Include: A record review of the facility's statement dated 3/31/2022 revealed, "(Proper Name of Facility) utilizes the RAI (Resident Assessment Instrument) for MDS (Minimum Data Set) guidance and submission." A record review of Centers for Medicare and Medicaid (CMS) RAI Version 3.0 Manual dated October 2019 revealed, "The Quarterly assessment is an OBRA (Omnibus Budget Reconciliation Act) non- comprehensive assessment for a resident that must be completed at least every 92 days ..." Resident #7 Record review of the "Identification and Summary	F 638	Resident #7, Resident #13, Resident #16, Resident #18, Resident #19, Resident #20, Resident #22, Resident #26, Resident #30, Resident #31, and Resident #35□s, Quarterly Minimum Data Set (MDS) was completed and submitted by Registered Nurse, (RN) Minimum Data Set (MDS) nurse on 3/30/22. Resident #10, Resident #23, Resident #27, and Resident #36□s Quarterly Minimum Data Set (MDS) was completed and submitted by Registered Nurse, (RN) Minimum Data Set (MDS) nurse on 3/31/22. Resident #33□s Quarterly Minimum Data Set (MDS) was completed and submitted by Registered Nurse, (RN) Minimum Data Set (MDS) nurse on 4/3/22. Resident #34□s Quarterly Minimum Data Set (MDS) was completed and submitted by Registered Nurse, (RN) Minimum Data Set (MDS) nurse on 4/7/22. Thirty-nine (39) residents have the potential to be affected by the deficient practice On 3/29/22 the Nurse Administrator in-serviced the MDS nurse on MDS Assessment and submission procedure and using the resident assessment instrument (RAI) Version 3.0 manual specified by Centers for Medicare and Medicaid (CMS.)	

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F 638	Continued From page 5 Sheet" revealed the facility admitted Resident #7 on 6/1/1976. Record review of the last completed MDS revealed a quarterly assessment with an ARD of 10/20/2021, which is more than 92 days. Resident #10 Record review of the "Identification and Summary Sheet" revealed the facility admitted Resident #10 on 4/2/2001. Record review of the last completed MDS revealed a significant change in status assessment with an ARD of 11/11/2021, which is more than 92 days. Resident #13 Record review of the "Identification and Summary Sheet" revealed the facility admitted Resident #13 on 3/4/2011. Record review of the last completed MDS revealed a quarterly assessment with an ARD of 10/13/2021, which is more than 92 days. Resident #16 Record review of the "Identification and Summary Sheet" revealed the facility admitted Resident #16 on 11/5/2021. Record review of the last completed MDS revealed an admission assessment with an ARD of 11/11/21, which is more than 92 days. Resident #18	F 638	The MDS nurse was provided more training on 3/30/22 on coding the MDS accurately and completing quarterly MDSs according to the MDS schedule by RN #3 MDS nurse. The MDS nurse will attend a MDS training workshop for extensive training on 4/28/22 offered by the State Agency. The facility created a Minimum Data Set Assessment policy and procedure that was reviewed and approved in the JNH Executive meeting on 4/14/22 and will be presented and approved by the Clinical Policy Committee by 4/28/2022. The Director of Nursing will review the MDS schedule beginning 3/30/22 and verify the MDS nurse has completed the MDS prior to submission weekly for two months then monthly for one month. Beginning 3/30/22 the Nurse Administrator will monitor the final Validation Reports weekly for one month then monthly thereafter. Beginning 3/30/22 the Director of Nurses will report any MDS inaccuracies weekly to the Nursing Home Administrator who will then report to the Quality Assurance Performance Improvement (QAPI) Committee on 4/27/22, then monthly for two months to ensure substantial compliance has been met. Should systemic changes not be effective QAPI will investigate and determine further action(s) needed based on findings.	

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F 638	Continued From page 6	F 638		

Record review of the "Identification and Summary Sheet" revealed the facility admitted Resident #18 on 8/22/2018

Record review of the last completed MDS revealed a quarterly assessment with an ARD of 11/17/2021, which is more than 92 days.

Resident #19

Record review of the "Identification and Summary Sheet" revealed the facility admitted Resident #19 on 5/18/2015.

Record review of the last completed MDS revealed an annual assessment with an ARD of 10/20/2021, which is more than 92 days.

Resident #20

A Record review of the "Identification and Summary Sheet" revealed the facility admitted Resident #20 on 6/10/2010.

A Record review of the last completed MDS revealed a comprehensive assessment with an ARD of 1/23/21, which is more than 92 days.

Resident #22

A Record review of the "Identification and Summary Sheet" revealed the facility admitted Resident #22 on 8/15/2018.

A Record review of the last completed MDS revealed a quarterly assessment with an ARD of 11/10/2021, which is more than 92 days.

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F 638	Continued From page 7	F 638		

Resident #23

Record review of the "identification and Summary Sheet" revealed the facility admitted Resident #23 on 8/27/2018.

Record review of the last completed MDS revealed a quarterly assessment with an ARD of 11/17/2021, which is more than 92 days.

Resident # 26

Record review of the "Identification and Summary Sheet" revealed the facility admitted Resident #26 on 08/10/2018.

Record review of the last completed MDS revealed an annual assessment with an ARD of 11/03/2021, which is more than 92 days.

Resident #27

A Record review of the "Identification and Summary Sheet" revealed the facility admitted Resident #27 on 4/4/2016.

A Record review of the last completed MDS revealed a quarterly assessment with an ARD of 11/10/2021, which is more than 92 days.

Resident #30

A Record review of the "Identification and Summary Sheet" revealed the facility admitted Resident #30 on 10/5/2015.

A Record review of the last completed MDS revealed a quarterly assessment with an ARD of 10/27/2021, which is more than 92 days.

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F 638	Continued From page 8	F 638		

Resident #31

A Record review of the "Identification and Summary Sheet" revealed the facility admitted Resident #31 on 8/16/2018.

A Record review of the last completed MDS revealed a quarterly assessment with an ARD of 11/3/2021, which is more than 92 days.

Resident #33

Record review of the "Identification and Summary Sheet" revealed the facility admitted Resident #33 on 10/17/2016.

Record review of the last completed MDS revealed a quarterly assessment with an ARD of 12/1/2021, which is more than 92 days.

Resident #34

Record review of the "Identification and Summary Sheet" revealed the facility admitted Resident #34 on 3/7/2019.

Record review of the last completed MDS revealed a significant change in status assessment with an ARD of 12/12/2022, which is more than 92 days.

Resident #35

Record review of the "Identification and Summary Sheet" revealed the facility admitted Resident #35 on 11/14/2019.

Record review of the last completed MDS

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F 638	Continued From page 9	F 638		

revealed a quarterly assessment with an ARD of 10/6/2021, which is more than 92 days.

Resident #36

Record review of the "Identification and Summary Sheet" revealed the facility admitted Resident #36 on 11/20/2019.

Record review of the last completed MDS revealed an annual assessment with an ARD of 11/10/2021 which is more than 92 days.

On 03/29/22 at 11:04 AM, in an interview with Registered Nurse #2 (RN)/MDS Nurse, she stated that the MDS assessments are not up to date because she took the position approximately three months ago and received training for one and a half (1 ½) weeks. After training, she was working on her own and it takes her longer to complete the MDS assessments. She confirmed that she is behind on completing assessments and she knows it is important for MDS assessments to be completed in a timely manner.

On 03/31/22 at 11:31 AM, in an interview with the Nursing Home Administrator (NHA)/ Nursing Home (NH) Director, he stated he was not aware the MDS assessments were not current, and he confirmed it is important for them to be up to date. The current MDS nurse took the position in October or November of 2021 and the Director of Nursing (DON) should check behind the MDS nurse. He stated the DON is also new in her position and she assumed the MDS nurse was completing assessments in a timely manner.

On 03/31/22 at 10:30 AM, during an interview with the Nursing Administrator, she explained the

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F 638	Continued From page 10 facility does not have a MDS Policy and the facility used the RAI Manual for reference in completing MDS assessments and MDS submissions. She reported she was not aware the MDS nurse was behind on MDS assessments.	F 638		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to accurately code the Minimum Data Set (MDS) regarding a urinary and bowel toileting program for one (1) of 26 MDS assessments reviewed. Resident #18 Findings include: A record review of the facility's statement dated 3/31/2022 revealed, "(Proper Name of Facility) utilizes the RAI (Resident Assessment Instrument) for MDS guidance and submission." Resident #18 A record review of the "Identification and Summary Sheet" revealed the facility admitted Resident #18 on 8/22/2018. A record review of Resident #18's Quarterly MDS with an Assessment Reference Date (ARD) of 11/17/2021 revealed diagnoses of Hypertension, Bipolar Disorder, Pseudobulbar affect, and Glaucoma. Resident #18 was independent for	F 641	Resident #18 was not on a urinary and bowel toileting program. A Minimum Data Set (MDS) modification for coding no on a urinary and bowel toileting program for resident # 18 was re-submitted by Registered Nurse, (RN) Minimum Data Set (MDS) nurse on 3/31/22. Based on the MDS Roster Matrix the facility identified that twenty-seven, (27) residents incontinent of bowel and bladder have the potential to be affected by the deficient practice. On 3/29/22 the Nurse Administrator in-serviced the MDS nurse on MDS Assessment and submission procedure and using the resident assessment instrument (RAI) Version 3.0 manual specified by Centers for Medicare and Medicaid (CMS) and ensuring that section H is coded correctly. On 3/30/22 and 3/31/30, the Nurse Administrator and RN #3 MDS nurse begin auditing all scheduled MDSs for accurate coding of urinary and bowel toileting program in	4/28/22

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F 641	Continued From page 11 toilet use and the coding for Section H0200 and H0500 revealed Resident #18 was on a urinary and bowel toileting program. His Brief Interview of Mental Status (BIMS) score was 13, which indicated he is cognitively intact. On 03/29/22 at 8:05 AM, during an interview with Director of Nursing (DON), she explained Resident #18 can complete his Activities of Daily Living (ADLS) on his own time and is independent. Resident #18 will occasionally have incontinent episodes, but he will change himself and he toilets independently. On 03/29/22 at 9:50 AM, during an interview with Certified Nurse Aide (CNA) #3, she explained Resident #18 walks to the shower and bathroom independently and he is not on any special bladder or bowel training program. At 1:40 PM on 03/29/22, during an interview with Resident #18, he explained he has no problems going to the bathroom and is able to go by himself. On 03/30/22 at 10:00 AM, during an interview with CNA #2, he explained Resident #18 has had occasional incontinent episodes with urine, but not with bowel movements. He confirmed Resident #18 does not use a urinal and is able to toilet self. He also stated the resident is not on any special toileting training program. At 11:00 AM on 03/30/22, during an interview the DON, she explained the facility currently does not have a bowel and bladder training program. She reported Resident #18 can toilet without assistance. She explained she did not know that RN #2 had coded Resident #18 on the MDS as	F 641	section H of the MDS and no problems with coding were noted. The MDS nurse was provided more training on 3/30/22 on coding the MDS accurately by RN #3 MDS nurse. The MDS nurse will attend a MDS training workshop for extensive training on 4/28/22 offered by the State Agency. The facility created a Minimum Data Set Assessment policy and procedure that was reviewed and approved in the JNH Executive meeting on 4/14/22 and will be presented and approved by the Clinical Policy Committee by 4/28/2022. Beginning 3/30/22, the Director of Nursing will audit section H on the MDS for accurate coding weekly for one month then monthly for two months. Beginning 3/30/22 the Director of Nurses will report any MDS inaccuracies weekly to the Nursing Home Administrator who will then report to the Quality Assurance Performance Improvement (QAPI) Committee on 4/27/22, then monthly for two months to ensure substantial compliance has been met. Should systemic changes not be effective QAPI will investigate and determine further action(s) needed based on findings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A197	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

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F 641	Continued From page 12 having been in a bowel and bladder training program and it is coded incorrectly, which is a MDS discrepancy. She explained she depends on the MDS nurse to code the MDS assessments accurately and to submit the MDS when assessments are due. She reported the facility currently does not check MDS assessments for accuracy prior to submitting. At 12:45 PM on 03/30/22, during an interview with RN #2, she reviewed Resident #18's recent MDS with an ARD of 11/17/21 and confirmed sections H0200 and H0500 were coded for a bowel and bladder training program. She explained Resident #18 goes to the bathroom on his own and he was not in a bowel and bladder training program during the seven day lookback period. She confirmed the MDS was coded in error, and it is a MDS discrepancy. On 03/30/22 at 12:50 PM, during an interview with RN #3, she viewed and confirmed Resident #18's Quarterly MDS with an ARD of 11/17/21 sections H0200 and H0500 were coded incorrectly due to Resident #18 had no orders for a bowel and bladder training program and those programs require an in-depth assessment. 03/31/22 at 10:30 AM, during an interview with the Nursing Administrator, she explained the facility does not have a MDS Policy, the facility used the RAI Manual for reference in completing the MDS. She confirmed the facility currently does not audit MDS assessments for accuracy prior to the MDS nurse submitting the assessments.	F 641		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		4/28/22

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F 689	Continued From page 13 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT 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 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	F 689	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 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	

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F 689	Continued From page 14 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.	F 689	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 determined by the committee. Should systemic changes not be effective QAPI will investigate and determine further action(s) needed based on findings.	