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
	31JC	A. BUILDING: _____ B. WING _____	01/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JASPER CO NH	15 A SOUTH SIXTH STREET BAY SPRINGS, MS 39422

(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 a State Licensure survey from 01/23/19 through 01/25/19. During the survey the SA determined the facility did not meet the licensure requirements for the State Minimum Standards for the Aged and Infirm. The SA cited M190, M500, M620, and M655. The facility was licensed for 120 beds, and had a census of 108 at the time of survey	M 000		
M 190	45.2.33 Restraint Restraint. The term "restraint" shall include any means, physical or chemical, which is intentionally used to restrict the freedom of movement of a person. This Statute is not met as evidenced by: Level II Based on observation, staff and resident interview, record review, and facility policy review, the facility failed to ensure Resident #306's right to be free from the use of a physical restraint device for one (1) of three (3) residents observed for restraint devices. Findings include; Review of the facility's policy titled, "Restraint Policy", with an updated and review date of 09/18/14, revealed it is the policy of this faciilty that restraints will be used as follows: Physical restraints are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's	M 190	1. Resident #306 was identified during the survey process; lap tray was removed by Director of Nurses. Resident #306 was then assisted to toilet by the Director of Nurses and the assigned Certified Nursing Assistant. She was then assisted by Director of Nurses and Certified Nursing Assistant to ambulate to the dining room for her lunch meal, where she sat in a regular dining chair with direct supervision by the Director of Nurses. After she finished her meal, she was assisted by the Director of Nurses into a wheelchair and taken to physical therapy department by the Director of Nurses for evaluation of the need for lap tray. Nursing Home Administrator assessed resident and found no ill effects of deficient practice. 2. All residents with positioning devices	3/6/19

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

Electronically Signed | 02/28/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31JC	A. BUILDING: _____ B. WING _____	01/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JASPER CO NH	15 A SOUTH SIXTH STREET BAY SPRINGS, MS 39422

(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 190	Continued From page 1 body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Restraints will be checked every 30 minutes and loosened and released every 2 (two) hours for a minimum of 5 (five) minutes. Code the Minimum Data Set (MDS) for restraint only if the device has the effect of restricting the resident's freedom of movement. If resident is immobile and cannot voluntarily get up,. a device should not be coded as a restraint. Reminders: Must have valid justification for the use of restraints. The use of restraints must be addressed on the Total Care Plan. Restraint usage should be reviewed at least quarterly for possible reduction. Must have a restraint consent signed by the resident or the responsible party. The possible negative outcomes of restraint use must be explained to the resident and/or responsible (party) before the restraint is applied except in emergency situation. Prior to the application of restraints the following should be done: Consider less restrictive measures-Positioning devices, Recliners, Diversional activities, Lowest chair height. On 01/23/18 at 11:45 AM, an observation revealed Resident #306 was in the dining room for lunch. Resident #306 was sitting in a Geri-chair with a lap tray in place on the Geri-chair. On 01/23/19 at 12:56 PM, an observation revealed Resident #306 was in the day room, and she was sitting in the Geri-chair with a lap tray in place. Resident #306 slid down in chair, but was able to push herself back up in the chair unassisted. On 01/24/18 at 12:05 PM, an observation revealed Resident #306 was in the dining room for lunch. Resident #306 was sitting at the table in	M 190	have the potential to be affected by cited deficient practice, 14 residents identified to have positioning devices at time of survey. There were no residents with physician ordered restraint devices at time of survey. 3. All residents with positioners have been evaluated by the Registered Nurse Supervisor, physical therapy/occupational therapy, and Director of Nurses, for the need for the device, and that the devices do not act as a restraint for the resident. A new evaluation form has been developed and will be completed on a resident prior to the application of a positioner/restraint device. The evaluation will include what interventions were tried prior to applying any device, and ensure that the least restrictive approach is attempted first. The evaluation will be completed by a Registered Nurse. All positioners and restraint devices require a physician' s order. On 01/25/2019 Nursing Home Administrator reviewed records on all residents using positioners. None were found to be in violation of policy. The lap tray on Resident #306 was discontinued on 01/25/2019. 4. The presence of a positioner/restraint is observed/documented every shift by the Treatment Nurse on the Electronic Treatment Administration Record, and by the Certified Nursing Assistant in eCare kiosk. The device will be monitored on a monthly basis by a Registered Nurse, physical or occupational therapist, and the Director of Nurses or Administrator for continued need/appropriate purpose. The Director of Nurses will give a report of device monitoring results monthly to Quality Assurance committee until	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31JC	A. BUILDING: _____ B. WING _____	01/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JASPER CO NH	15 A SOUTH SIXTH STREET BAY SPRINGS, MS 39422

(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 190	Continued From page 2 a Geri-chair with the lap tray off. On 01/24/19 at 4:34 PM, an observation and interview revealed Resident #306 was in the TV room talking with an Activity staff person. Resident #306 asked why she has this tray on. Resident #306 stated I can't get up to do anything, and nobody else in here has one on. I can't go forward, I can't go backwards, I can't go sideways, I can't do anything with this thing on. On 01/25/19 at 8:15 AM, an observation revealed Resident #309 was sitting in a Geri- chair at a table in the dining room with the lap tray off. Resident #306 was alert, and conversing with other ladies at the table. On 01/25/19 at 8:30 AM, an observation revealed Resident #306 was sitting in the TV room in a Geri chair with the lap tray off. Resident #306 was calm, her eyes were closed, with her head down. On 01/25/19 at 9:44 AM, an observation and interview revealed Resident #306 stood up from the Geri- chair, this surveyor walked toward her as she stumbled, and held her arm to steady her. The Activity Assistant walked through the TV room at this time, and assisted the resident to sit down. Further observation revealed the resident's lap tray was hanging on the side of the chair. Resident #306 stated don't put that on me. The Activity Assistant stated she would check with someone. On 01/25/19 at 10:12 AM, an observation revealed Resident #306 stood up from the Geri-chair again as Certified Nursing Assistant (CNA) #9 walked by pushing the ice cart, and was alerted Resident #306 was standing. CNAs #9 and #10 assisted Resident #306 to sit back down,	M 190	compliance achieved and for recommendations for improvement. Devices will be removed or changed per physician order at the time a change/removal is indicated/recommended.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31JC	A. BUILDING: _____ B. WING _____	01/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JASPER CO NH	15 A SOUTH SIXTH STREET BAY SPRINGS, MS 39422

(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 190	Continued From page 3 and reclined the Geri-chair. On, 01/25/19 at 11:13 AM, during an interview with the Administrator (ADM) she stated a restraint assessment was not done because the Geri-chair was not a restraint. The Administrator stated the resident can remove the tray. The ADM confirmed there was no documentation of measures taken prior to placing Resident #306 in a wheelchair (w/c) with a lap buddy, nor the Geri-chair with a tray. On 01/25/19 at 11:45 AM, an observation and interview revealed Resident #306 was sitting in a Geri-chair with the lap tray in place. The DON was present. Resident #306 stated she did not like the tray on her, it is uncomfortable and it makes her smother. The DON asked Resident #306 if she could remove the tray, and the resident stated she could not remove it, and didn't have any idea how to get it off. The DON and a CNA asked Resident #306 if she would like to walk, and she said yes, just get me out of this thing. Resident #306 ambulated with minimal assistance greater than 100 feet to the dining room. On 01/25/19 at 3:00 PM, an interview with the DON revealed Resident #306 ambulated over 100 feet with assistance. The DON stated Resident #306 was able to bear her own weight, and felt she could ambulate with the assistance of one person. On 01/25/19 at 1:37 PM, an interview with the Licensed Physical Therapy Assistant confirmed that therapy was not consulted prior to Resident #306 being placed in a w/c with lap buddy or the Geri chair with the tray. She confirmed if the resident could not rise from the chair it would be	M 190		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31JC	A. BUILDING: _____ B. WING _____	01/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JASPER CO NH	15 A SOUTH SIXTH STREET BAY SPRINGS, MS 39422

(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 190	Continued From page 4 considered a restraint. Review of Resident #306's Admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/23/19, revealed a Basic Interview for Mental Status (BIMS) score of 8, which indicated moderate cognitive impairment. Resident #306 was not coded for the use of a Restraint Device. Resident #306 required limited assistance with one person physical assistance with transfers, extensive assistance with one person assist for locomotion on the unit, and total assistance of one person off the unit, extensive assistance of one person for walking in the room/corridor, extensive assistance with one person assist with dressing, toilet use, and personal hygiene. For walking (with assistive device if needed) she was coded a 2, which indicated Resident #306 was not steady, and only able to stabilize with one person assistance. Resident #306 did not have any Range of Motion (ROM) impairments to any of her four extremities, and used a wheelchair for locomotion.	M 190		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents;	M 500		3/6/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31JC	A. BUILDING: _____ B. WING _____	01/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JASPER CO NH	15 A SOUTH SIXTH STREET BAY SPRINGS, MS 39422

(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 500	Continued From page 5 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31JC	A. BUILDING: _____ B. WING _____	01/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JASPER CO NH	15 A SOUTH SIXTH STREET BAY SPRINGS, MS 39422

(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 500	Continued From page 6 grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31JC	A. BUILDING: _____ B. WING _____	01/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JASPER CO NH	15 A SOUTH SIXTH STREET BAY SPRINGS, MS 39422

(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 500	Continued From page 7 recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and	M 500		

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
	31JC	A. BUILDING: _____ B. WING _____	01/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JASPER CO NH	15 A SOUTH SIXTH STREET BAY SPRINGS, MS 39422

(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 500	Continued From page 8 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level II Based on staff interview, and and facility policy review, the facility failed to make prompt efforts to resolve a resident's grievance for one (1) of 24 residents reviewed, for Resident #44. Findings Include: A review of the facility's policy titled, "Grievance/Complaint Policy", no date, revealed it was the policy of the facility that residents had the right to voice grievances, oral or written, and grievances should be reported to the Director of Nursing (DON) or Administrator. The policy further revealed grievances could be considered any problems or concerns affecting the resident, and when grievances were reported a grievance complaint form should be completed and maintained by the DON or designee. An interview and observation, on 01/23/19 at 11:45 AM, revealed Resident #44 was seated in the hallway in her wheelchair. The resident stated she didn't want to cause any trouble, but she had a problem with Resident #9 attempting to touch her when she did not want him to. Resident #44 stated she had told the nursing staff numerous times, and she wasn't the only person who felt this way. Resident #44 stated Resident #9 also went into resident's rooms uninvited.	M 500	1.Resident #44 grievance was identified during survey process. Resident #44 was assessed by the Registered Nurse Supervisor immediately upon notification 01/23/2019. Resident denied and no evidence of actual harm, nor did resident feel there was intent to harm. Chief Executive Officer met with Resident #9 in Officer' s office on 01/23/2019 regarding touching other residents without their permission. Nursing Home Administrator met with Resident #9 on 01/25/2019 regarding abstaining from touching other residents without their permission. Nursing Home Administrator met with Resident #44 on 01/25/2019 in resident s private room. Reviewed with Resident #44 reporting grievances and procedure of notifying the Director of Nurses, Administrator, or Social Worker if concerns/grievances are not addressed promptly or to resident s satisfaction. Nursing Home Administrator reconfirmed with Resident #44 that no actual harm or sense of threat/danger was felt. 2.All residents in the facility have the potential to be affected by this deficient practice. 3.The Grievance Policy and the Abuse, Neglect, and Exploitation of Vulnerable Adult Policy were reviewed with no revision necessary. Meeting held on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31JC	A. BUILDING: _____ B. WING _____	01/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JASPER CO NH	15 A SOUTH SIXTH STREET BAY SPRINGS, MS 39422

(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 500	Continued From page 9 An interview, on 01/23/19 at 12:08 PM, with Certified Nursing Assistant (CNA) #6 revealed Resident #9 liked women, and was "flirty" with them. CNA #6 stated residents had complained about him coming in their rooms uninvited, and they didn't want him in their room. An interview, on 01/23/19 at 12:23 PM, with CNA #7 revealed Resident #44 had complained to her frequently that she didn't like Resident #9 touching her. CNA #7 stated Resident #44 liked to pick at people, went in other resident's rooms, and hugged on all the women. It was just his personality. An interview, on 01/23/19 at 3:14 PM, with Licensed Practical Nurse (LPN #1) revealed this morning Resident #44 had complained to her that Resident #9 touched her and she did not like it. LPN #1 stated she was aware of another time Resident #44 complained about Resident #9. LPN #1 stated on that occasion she was working, and Resident #44 approached her stating Resident #9 was trying to hug on her and she did not want him to. LPN #1 stated she encouraged Resident #9 to leave Resident #44 alone, but he continued to attempt to hug her. LPN #1 stated she stepped between the residents, both in wheelchairs, and Resident #9 reached around her to touch Resident # 44 who backed up to get away from him. LPN #1 stated she reported this to the DON. LPN #1 stated she was unsure how long ago this happened, but it was at least three months ago. An interview, on 01/24/19 at 3:49 PM, with Social Services Staff (SS #1) revealed she generally handled grievances, and she or Administrative staff (Administrator or DON) would investigate	M 500	01/28/2019 by Nursing Home Administrator with Chief Executive Officer, Director of Nurses, Assistant Director of Nurses, and all Registered Nurse Supervisors regarding grievance reporting/handling procedure/policy and review of documentation forms. Registered Nurse Supervisor will visit residents daily and allow reporting of problems/grievances. Director of Nurses, Nursing Home Administrator, and Chief Executive Officer maintain open door policy for staff, residents, families, and public. A notice of all department directors involved in care and environment with office numbers, in addition to the home phone number of Nursing Home Administrator, is posted exit side of all resident room doors. On 03/01/2019, memo posted by Nursing Home Administrator regarding proper reporting of resident grievances. Grievances will be addressed/handled when reported to facility staff. Social Worker will remind residents at monthly Resident Council meetings of the proper way to report grievances. 4.The Director of Nurses will report to the Quality Assurance committee monthly of monitoring and negative findings reported until compliance achieved. Nursing Home Administrator or Chief Executive Officer will be notified of all grievances. Negative findings will be reported to and handled by the Nursing Home Administrator or Chief Executive Officer.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31JC	A. BUILDING: _____ B. WING _____	01/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JASPER CO NH	15 A SOUTH SIXTH STREET BAY SPRINGS, MS 39422

(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 500	Continued From page 10 and resolve grievances. SS #1 was not aware that Resident #44 did not want Resident #9 touching her. SS #1 stated she would expect that if there was an issue with touching, she or the Administrator would be told. SS #1 stated if a resident voiced a grievance to a nurse she would expect the nurse to report it. SS #1 stated there had been a grievance voiced to her by Resident #39 several months ago that she did not want Resident #9 coming to her room or touching her. SS #1 stated this had been addressed in a meeting with Resident #9 and #39, SS #1 and the Administrator. SS #1 stated the Administrator had spoken to Resident #9 many times regarding his behavior. An interview, on 01/25/19 at 9:01 AM, revealed the DON and Administrator confirmed the DON was informed by LPN #1 Resident #44 voiced a complaint that she did not want to be touched by Resident #9, and that Resident #9 continued to attempt to touch Resident #44 after redirection. The DON stated at the time she reviewed video surveillance of the area the incident occurred, and was not able to confirm the report because the residents were in an area without a good camera angle. The DON stated she did not interview Resident #44 or Resident #9 at the time, and she should have. The DON stated she would consider the report to be a grievance and should have investigated further. Review of Resident #44's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/21/18, revealed a Basic Interview for Mental Status (BIMS) score of 15, which indicated no cognitive impairment.	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31JC	A. BUILDING: _____ B. WING _____	01/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JASPER CO NH	15 A SOUTH SIXTH STREET BAY SPRINGS, MS 39422

(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 620	Continued From page 11	M 620		
M 620	45.21.4 Urinary incontinence Urinary incontinence. Residents with urinary incontinence shall be assessed for need of bladder retraining program. An indwelling catheter will not be used unless the resident ' s clinical condition indicates that catheterization is necessary. These residents shall receive treatment and services to prevent urinary tract infections. Level II Based on observation, staff interview, record review, and facility policy review, the facility failed to provide catheter care in a manner to prevent the possibility of cross contamination, and to provide securing devices for the catheter tubing to prevent the possibility of pain/discomfort, and trauma to the urethra for three of four (3 of 4) residents observed with urinary catheters. Residents #46, #65, and #77. Findings include: A review of the facility's policy titled, "Catheter Care Policy", undated revealed, it is the policy of this facility that catheter care will done as follows: Wash hands. Don gloves. Remove and clean any bowel movement (BM). Remove soiled gloves and dispose. Wash hands. Cleanse the catheter from the body to the end of the catheter, never from the end of the catheter toward the body and do not pull the catheter. Pat peri-area dry with towel, unless Disposable Wipes are used. Remove gloves and dispose. Review of the facility policy titled, "Catheter Placement Policy", no date, revealed it is the policy of this facility that urinary catheters and drainage bags will be properly placed to ensure	M 620	1.Upon notification of deficient practice during survey process, the Certified Nursing Assistant responsible for the care of Resident #65 and Resident #77 was instructed to apply catheter strap immediately. Registered Nurse Supervisor confirmed that this was completed and that the resident showed no signs of ill effects. Certified Nursing Assistant for Resident #46 was verbally counseled by Registered Nurse Supervisor, discussing the identified deficient practice, and reviewing the facility policy and procedure for catheter care. The residents were checked by their primary physicians on 01/29/2019, and were found to have no adverse effects resulting from deficient practice. 2.At the time of survey, there were four residents with indwelling catheters, all of which were at risk to be affected by deficient practice. 3.Statement was added to Certified Nursing Assistant electronic charting on 02/25/2019, reminding them to check for catheter strap placement and documented each shift. Order was also added to Treatment Administration Record on 02/25/2019, for medication/treatment nurse to check for catheter strap	3/6/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31JC	A. BUILDING: _____ B. WING _____	01/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JASPER CO NH	15 A SOUTH SIXTH STREET BAY SPRINGS, MS 39422

(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 620	Continued From page 12 adequate drainage as follows: Always position the drainage bag lower than the residents thigh at all times using a catheter leg strap, tape or other method. A review of the facility's policy titled. "Incontinent Care Policy", undated, revealed it is the policy of this facility that incontinent care will be handled to ensure that all incontinent residents will receive appropriate treatment and services to prevent urinary tract infections. The Procedure included: Don gloves, if BM present, cleanse BM before starting incontinent care. Remove gloves and dispose. Don gloves. Cleanse perineal area from front to back. Rinse well using clean cloth and water. Remove gloves and dispose properly. Wash hands. Don gloves. Apply incontinent care product. Remove gloves and dispose of properly. Wash hands. Don gloves. Use diapers or pad, as indicated. Cover resident. Remove gloves and dispose of properly. Resident #46 On 01/23/19 at 11:49 AM, an observation revealed, Resident #46 was sitting in his wheelchair at his bedside. Resident #46 had an indwelling urinary catheter in place. Resident #46 stated he had the urinary catheter because he started having trouble urinating. Resident #46's urinary catheter bag was observed in a dignity bag and hanging to gravity drainage. On 01/23/19 at 11:55 AM, an interview with Licensed Practical Nurse (LPN) #2, revealed Resident #46 had an indwelling urinary catheter because he had a diagnosis of Prostate Cancer. On 01/23/19 at 2:30 PM, an observation revealed Resident #46 was lying in bed, awake and talking	M 620	placement each shift. All newly hired Certified Nursing Assistants will be checked off on proper catheter care during their initial orientation by the Assistant Director of Nurses. All current Certified Nursing Assistants were divided among 5 Registered Nurses and will be checked off on catheter care through direct observation beginning 01/31/2019, and all check offs will be completed by 03/06/2019. Check offs will be done quarterly by the Registered Nurses assigned to this task. For those residents with indwelling catheters, Registered Nurse Supervisors will monitor direct care once per month at random unscheduled times until compliance is achieved. 4.Registered Nurse Supervisors will report monthly findings to the Quality Assurance nurse. Any Certified Nursing Assistant found to be performing care improperly will be counseled and disciplined accordingly by the Registered Nurse Supervisor. Quality Assurance nurse will report monthly to the Quality Assurance committee for recommendations for improvement. Registered Nurse Supervisors will report status of quarterly check off completion to Director of Nurses.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31JC	A. BUILDING: _____ B. WING _____	01/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JASPER CO NH	15 A SOUTH SIXTH STREET BAY SPRINGS, MS 39422

(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 620	Continued From page 13 to Certified Nursing Assistant (CNA) #1. The Surveyor observed CNA #1 and CNA #2 provide catheter care for Resident #46. CNA #1 washed her hands, applied clean gloves, set up supplies on a clean barrier, and pulled the covers back on Resident #46. Wearing these same gloves, CNA #1 wiped Resident #46 with a downward stroke on each side of his penis, in the groin areas. CNA #1 then wiped Resident #46's catheter tubing in an outward motion from the base of the penis towards the meatus without securing the catheter tubing. CNA #1 then wiped the catheter tubing from the meatus area towards the base of Resident #46's penis. CNA #1 then pulled the cloth brief back up on Resident #46, covered him up, removed her soiled gloves, and washed her hands. On 01/24/19 at 3:35 PM, an interview with the Director of Nurses (DON), revealed the gloves the CNA #1 was wearing touched Resident #46's linens, and she (CNA #1) should have changed her gloves after she (CNA #1) touched his (Resident #46) linens. The DON also stated, CNA #1 should have held the catheter tubing while wiping it to prevent trauma to the prostate. The DON stated when CNA #1 wiped from the base of the penis to the meatus, the CNA was pushing the bacteria back into the meatus which can cause an infection. On 01/24/19 at 3:40 PM, an interview with Registered Nurse (RN) #2 revealed, CNA #1 did not hold the catheter tubing, and she should have held the catheter tubing while wiping, because she could cause pulling on the tube. RN #2 also stated, using the same glove hands to provide catheter care that she used to pull Resident #46's covers back, contaminated the gloves, and she (CNA #1) should have taken the gloves off,	M 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31JC	A. BUILDING: _____ B. WING _____	01/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JASPER CO NH	15 A SOUTH SIXTH STREET BAY SPRINGS, MS 39422

(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 620	Continued From page 14 washed her hands and applied clean gloves. RN #2 also stated instead of wiping from the base of the penis towards the meatus, CNA #1 should have wiped from the meatus towards the base to prevent bacteria from entering the meatus. On 01/25/19 at 8:50 AM, an interview with CNA #1, revealed the catheter could come out if it is not held while wiping it. CNA #1 also stated she should have changed her gloves after pulling the covers back. Review of the Physician Orders, for January 2019, revealed an order to change the Foley catheter every six weeks; 18 French (Fr) 5 Cubic Centimeter (cc) Coude Catheter, catheter care twice a day, change Foley drainage bag every 2 weeks and as needed. Review of the Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/01/18, and the Comprehensive MDS, with an ARD of 09/03/18, revealed Resident #46 was coded for an indwelling urinary catheter. The Quarterly MDS, with an ARD of 12/01/18, revealed a Basic Interview for Mental Status (BIMS) score of 12, which indicated moderate cognitive impairment. A review of the Face Sheet revealed Resident #46 was admitted by the facility, on 02/10/98, with the included diagnoses of Hemiplegia/Hemiparesis and Retention of Urine. Resident #65 During an observation, on 01/23/2019 at 4:03 PM, of Resident #65's catheter care provided by Certified Nursing Assistant (CNA) #3, it was observed there was no device in place to secure	M 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31JC	A. BUILDING: _____ B. WING _____	01/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JASPER CO NH	15 A SOUTH SIXTH STREET BAY SPRINGS, MS 39422

(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 620	Continued From page 15 the catheter tubing to prevent tugging on or dislodgement of the catheter.. Review of the Resident #65's Physician's Orders, for January 2019, revealed an order dated 09/09/2018 for catheter care to be performed twice daily (BID), Certified Nursing Assistant (CNA) may perform. During an interview on, 01/23/2019 at 4:12 PM, CNA #3 confirmed there was no securing device in place for Resident #65's catheter tubing during the catheter care. CNA #3 stated, if one of her residents didn't have a leg strap for their catheter, she would go get one and put it on. CNA #3 stated she was responsible for placing catheter straps on residents with catheters. During an interview, on 01/24/19 at 12:00 PM, with Registered Nurse (RN) #4/Minimum Data Set (MDS) /Care Plan Coordinator, revealed the use of a catheter strap, is included in the catheter care protocol. RN #4 stated it is the facility's practice to use a catheter tubing strap for all residents with catheters, to prevent tugging and possible injury. RN #4 stated that Resident #65 should have had a catheter strap. RN #4 stated that all CNAs should make sure catheter straps are in place. During an interview, on 01/24/2019 at 3:53 PM, with RN #3/ Station Three (3) Supervisor, she stated she conducts unplanned catheter care observations with CNAs to check off the CNA's skills. RN #3 also stated she does not keep a record of the CNA skills check offs. During an interview, on 01/24/2019 at 3:58 PM, with RN #5/ Restorative Nurse, she stated she does random, and as needed, inservices related	M 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31JC	A. BUILDING: _____ B. WING _____	01/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JASPER CO NH	15 A SOUTH SIXTH STREET BAY SPRINGS, MS 39422

(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 620	Continued From page 16 to CNA duties. RN #5 stated that catheter care was included in the inservices provided. During an interview, on 01/25/2019 at 8:45 AM, RN #3/ Station 3 Supervisor revealed that part of the skills check-offs she does for the CNAs, is to check for the catheter strap during the catheter care task. RN #3 confirmed that a catheter strap should have been applied for Resident #65, when the CNA noticed that it was missing. During an interview, on 01/25/2019 at 8:29 AM, the Director of Nursing (DON) stated that while providing catheter care, it a standard practice of the facility to use a catheter strap. The DON stated that a catheter strap should be in place for all residents with catheters to prevent possible dislodgement or trauma. The DON confirmed that in-services and skills check-offs are provided to the Nursing staff, no less than annually, and as needed. During an interview, on 01/25/2019 at 8:59 AM, CNA #4 revealed catheter straps should be used for all residents who have catheters. CNA #4 stated, part of doing catheter care is to make sure the strap is in place. CNA #4 stated if there is not a strap, straps are available to get one. Review of the Face Sheet revealed Resident # 65 was admitted by the facility, on 12/05/2014, with diagnoses to include Alzheimer's disease and Neuromuscular Dysfunction of Bladder. Review of Resident #65's Significant Change MDS, with an ARD of 12/11/18, revealed she was coded a 3 for Cognitive Skills for Daily Decision Making, which indicated rarely or never makes decisions. Resident #65 was checked for the use of an indwelling catheter.	M 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31JC	A. BUILDING: _____ B. WING _____	01/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JASPER CO NH	15 A SOUTH SIXTH STREET BAY SPRINGS, MS 39422

(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 620	Continued From page 17 Resident #77 An observation during Resident #77's catheter care, on 01/24/18 at 11:10 AM, revealed Resident #77 did not have an anchor for the catheter to prevent pulling. The catheter care was provided by CNAs #11 and #12. An interview, on 01/25/19 at 08:50 AM, with CNA #12 confirmed Resident #77 did not have a leg strap on. CNA #12 stated Resident #77 does not like to wear them. An interview, on 01/25/19 at 8:55 AM, with Resident #77, revealed the strap irritated her leg, so she usually does not wear one. She stated she does have discomfort due to her catheter pulling at times. She stated it is worse when they are pulling up her brief. Resident #77 confirmed they have not tried any another kind of device to secure the catheter to her leg. An interview, on 01/25/19 at 8:55 AM, with the Director of Nursing (DON), confirmed Resident #77 should have her catheter secured to her leg. She stated she was not aware the leg strap bothered her, but stated she needs something to secure it. The DON stated the resident could experience pulling, irritation, or pain if the catheter is not secured. Review of Resident #77's Quarterly MDS, with an ARD of 12/22/18, revealed a BIMS score of 8, which indicated moderate cognitive impairment. Resident #77 was also checked for the use a an indwelling catheter.	M 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31JC	A. BUILDING: _____ B. WING _____	01/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JASPER CO NH	15 A SOUTH SIXTH STREET BAY SPRINGS, MS 39422

(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 655	Continued From page 18	M 655		
M 655	45.21.11 Special needs Special needs. Each resident with special needs shall receive proper treatment and care. These special needs shall include, but are not limited to injections; parenteral and enteral fluids; colostomy, ureterostomy, ileostomy care; tracheostomy care; tracheal suction; respiratory care; foot care; and prostheses. This Statute is not met as evidenced by: Based on observation, resident interview, staff interview, record review, resident interview and facility policy review, the facility failed to store the resident Continuous Positive Airway Pressure (CPA) mask in a manner to prevent possible infection for one (1) of seven (7) residents observed for respiratory care. Findings include: A review of the facility's policy titled, "Infection Control Program Policy", undated, revealed, it is the policy of this facility that the Infection Control Program will be designed to help prevent the development and transmission of disease and infection. On 1/23/19 at 10:57 AM, an observation of Resident #94'S CPA mask revealed, the mask was uncovered, un-bagged, and lying on a white wash cloth on top of his CPA machine, on his nightstand. Resident #94 was lying in bed with his oxygen (O 2) in place, and the head of his bed (HOB) was up. On 1/23/19 at 2:20 PM, an observation of Resident #94's CPA mask revealed, the CPAP was lying un-bagged on a white washcloth on top	M 655	1. Resident #94 s CPAP mask was cleaned and properly stored in plastic bag at bedside by Registered Nurse Supervisor at the time the deficient practice was identified during survey process. Resident #94 was seen by primary physician on 01/29/2019 and found to have no adverse respiratory conditions related to deficient practice. 2. Twenty-four residents identified to have respiratory masks/equipment at time of survey, all with the potential to be affected by deficient practice. 3. The twenty-four residents identified were checked by the Medication/Treatment nurses on duty at the time of survey to ensure all respiratory supplies were appropriately bagged. The supplies of all other residents were found to be appropriately placed in plastic bags. An order was placed on the Medication Administration Record on 02/25/2019 for all residents with respiratory treatments for the Medication Nurse to document at the end of each shift that supplies were appropriately bagged during their shift. Registered Nurse Supervisors were notified by Director of Nurses on	3/6/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31JC	A. BUILDING: _____ B. WING _____	01/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JASPER CO NH	15 A SOUTH SIXTH STREET BAY SPRINGS, MS 39422

(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 655	Continued From page 19 of his CPAP machine on his nightstand. On 1/24/19 at 11:45 AM, an observation of Resident #94's CPAP mask revealed the CPAP mask continued to be un-bagged, and laying on the white washcloth on top of the CPAP machine. On 1/24/19 at 4:45 PM, an observation of Resident #94's CPAP mask revealed the CPAP mask was un-bagged, and laying on the white washcloth on top of the CPAP machine. Review of the Physician Orders, for January 2019, revealed an order dated 09/09/16. to apply CPAP (nasal) 13 centimeter (CM) with O2 at 2 liters per minute (L/Min), clean CPAP mask with water after removal and let air dry, clean CPAP water chamber and tubing with solution of 1/3 vinegar to 2/3 water, rinse thoroughly with clean water and air dry, empty CPAP water and refill with fresh water. Review of Resident #94's Care Plan revealed the Problem/Need, dated 10/03/19, for the diagnoses Sleep Apnea, Chronic Obstructive Pulmonary Disease (COPD), Acute Respiratory Failure, and Episodes of Respiratory Distress. The Approaches included CPAP as ordered at HS (hour of sleep). On 1/23/19 at 10:57 AM, an interview with Resident #94 revealed the nurse put the CPAP mask there when she took the CPAP mask off and cleaned it. Resident #94 stated it was a female nurse because there are no male nurses working here (at the facility). On 1/24/19 at 3:25 PM, an interview with Registered Nurse (RN) #1 revealed, "I think we leave the CPAP mask on the bedside table." RN	M 655	02/25/2019 to include same orders for any resident who receives new order for respiratory treatments. Registered Nurse Supervisors will make weekly checks at various times to ensure that supplies are being bagged appropriately. 4. Registered Nurse Supervisors will report monthly findings to Quality Assurance nurse. Quality Assurance nurse will report monthly to the Quality Assurance committee for recommendations for improvement until compliance achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31JC	A. BUILDING: _____ B. WING _____	01/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JASPER CO NH	15 A SOUTH SIXTH STREET BAY SPRINGS, MS 39422

(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 655	Continued From page 20 #1 stated, the CPAP mask should be stored in a plastic bag to keep germs from getting on the mask. On 1/24/19 at 3:35 PM, an interview with the Director of Nurses (DON) revealed the CPAP mask should be put in a zip lock bag. The DON stated she was not sure why that is not being done. Review of the Face Sheet revealed Resident #94 was admitted by the facility, on 02/06/15, with the included diagnoses of Sleep Apnea, COPD, Morbid Obesity, and other Diseases of the Respiratory System. Review of the Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/01/19, revealed a Basic Interview for Mental Status (BIMS) of 15, which indicated no cognitive impairment.	M 655		

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
	31JC	A. BUILDING: **01 - MAIN BUILDING 01** B. WING _____	**01/24/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JASPER CO NH	**15 A SOUTH SIXTH STREET BAY SPRINGS, MS 39422**

(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
M1245	45.41.1 Date of Construction & Life Safety... Date of Construction and Life Safety Code Compliance. 1. Buildings constructed after the effective date of these regulations shall comply with the edition of the Life Safety Code (NFPA 101) effective on the date of construction. 2. Buildings constructed prior to the effective date of these regulations shall comply with Chapter 13 of the Life Safety Code (NFPA 101), 1985 edition. This Statute is not met as evidenced by: Based on record review, the facility failed to provide a properly maintained fire alarm system as required by NFPA 72 Table 14.3.1. This deficiency affected all 110 residents in the facility at the time of survey. Findings include: On January 24, 2019 at 11:30 AM, observation and record review revealed the facility was unable to provide the current year (2018) documentation of annual and sensitivity inspection of the fire alarm system. Record review also revealed the last annual and sensitivity inspection of the fire alarm system was conducted on June 2017. The administrator was made aware of the issue during the exit conference.	M1245	American Fire and Safety conducted annual sensitivity inspection of the facility fire alarm system. All residents had the potential to be affected by this deficient practice. The facility recently experienced a turn over in Maintenance Director position. The new Director has added this annual inspection to the preventive maintenance schedule and will be completed prior to annual due date. Maintenance Director will update to the facility safety committee at least quarterly on the status of preventive maintenance items due to be completed. Maintenance director will report on annual basis to QAPI of completion of this testing.	2/27/19

Mississippi State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/28/19