STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A402	A. BUILDING _____ B. WING _____	C 08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JNH-JEFFERSON INN	3550 HWY 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 a Complaint Investigation (CI) for three (3) complaints, CI MS #18756, CI MS #18755, and CI MS #18636 at the facility from 8/22/22 through 8/24/22. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid. SA substantiated CI MS #18636 for abuse and cited F600. The SA did not substantiate CI MS #18756 for sexual abuse or CI MS #18755 for quality of care/treatment. The facility held a license for 80 beds, with a census of 75.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interviews, record reviews, and facility policy review, the facility failed to protect a resident's right to be free from abuse for one (1) of five (5) residents sampled for abuse. Resident	F 600	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	10/14/22

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

Electronically Signed | 09/08/2022

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F 600	Continued From page 1 #1 Findings include: Review of the facility's policy titled "INJURIES, ABUSE, NEGLECT, MISTREATMENT, MISAPPROPRIATION OF RESIDENT PROPERTY OR EXPLOITATION OF RESIDENTS", dated July 2021, revealed ... "(Proper name of facility) residents have a right to be free from abuse ...Physical abuse includes hitting, slapping, pinching, and kicking ..." Record review of a document listing the facility's incidents and accidents, revealed an entry dated 2/17/22 at 3:30 PM, for Resident #1 with the description of the event/incident as "It was reported that Resident (#1) was sitting in his wheelchair in the male dayroom when Certified Nurse Aide (CNA) #1 approached him. They began having a conversation when Resident (#1) began cursing. Staff heard CNA (#1) asking Resident (#1) "What the (expletive) did I do to you?" Resident #1 began to leave the dayroom when it was alleged that CNA (#1) kicked the back of his wheelchair. Staff was removed off the building, later placed on administrative leave until the conclusion of the investigation ..." Review of "Investigative Findings" dated 2/23/22, revealed that the Department of Safety & Investigative Services was advised of the possible physical abuse of Resident #1 on 2/17/22, at 3:20 PM. The four (4) employees that witnessed the incident were interviewed and although only two (2) of the witnesses were able to hear CNA #1 curse at the resident, all four (4) witnesses confirmed that they saw CNA #1 hit the back of his wheelchair with her foot with enough	F 600	Immediate action(s) taken for the resident(s) found to have been affected include: Resident # 1 was immediately assessed by Registered Nurse 02/17/2022, and found no negative outcomes. Certified Nursing Assistant (CNA)#1 was immediately removed off the building by the Nursing Home Administrator and was sent home on 02/17/2022 pending the outcome of the investigation. The facility□s Safety and Investigative Services findings were that Physical Abuse was substantiated against CNA #1. CNA #1 was terminated on 03/10/2022. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice? The facility has determined that 75 residents had the potential to be affected, resident #1 was affected. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? On 02/17/2022, CNA#1 was immediately verbally counseled by the Nursing Home Administrator on Abuse and Neglect. On 02/17/2022, the Director of Nurses in-serviced all staff on the suspicion of abuse, neglect, and exploitation and reporting and investigating incidents. On 03/13/2022, the RN Nurse Supervisor in-serviced all staff of suspicion of abuse, neglect and residents□ injuries of	

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F 600	Continued From page 2 force to propel the wheelchair forward. The report revealed "Finding: PHYSICAL ABUSE - SUBSTANTIATED." Upon completion of the investigation, the matter was referred to the Administrator and Human Resources Department for disposition. On 8/22/22 at 4:30 PM, an interview with the Administrator revealed she was aware of the allegation of abuse of Resident #1 by (CNA) #1. She stated a complete investigation was conducted and the allegation of abuse was confirmed. Immediately following the report of abuse to the nurse on 2/17/22, the CNA #1 was removed from resident care to ensure the protection of residents, pending the outcome of the investigation, and terminated upon completion. She confirmed she had reported the incident to the State Agency (SA) and the Attorney General's Office (AGO). On 8/23/22 at 10:30 AM, an interview with CNA #2 revealed was she working on 2/17/22 and witnessed CNA #1 enter the male day room and engage in conversation with Resident #1. CNA #2 said she heard Resident #1 "getting loud and cursing" and she verbalized a warning to CNA #1 to leave Resident #1 and let him calm down, but she said Resident #1 was so loud she did not think CNA #1 could hear her. She stated she did not see Resident #1 strike out at CNA #1, but she saw CNA #1 back away from Resident #1 abruptly and heard CNA #1 say to Resident #1 "What the (expletive) did I do to you?" She stated CNA #1 walked behind Resident #1, "lifted her foot and kicked the back of Resident #1's wheelchair and it just took off across the room". CNA #2 said she immediately got up and went and reported the incident to RN #1. CNA #2	F 600	unknown causes. On 08/24/2022, the Director of Nursing in-serviced all staff addressing the importance of reporting abuse and neglect incidents. Newly hired nursing staff will be in-serviced upon hire, quarterly, and as needed by the Director of Nursing on Abuse and Neglect which includes Residents□ Rights and Dignity. Beginning 08/31/2022, an in-service video on abuse and neglect was conducted with all staff by the Criminal Investigator with the Attorney General□s office. 4. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated in to the quality assurance system. Beginning on 09/2/2022, the Director of Nursing will interview 5 residents to address the issues and understanding of abuse, neglect, dignity, resident□s rights, and importance of reporting abuse weekly for one month, then monthly for one month, using the Abuse and Neglect Interview Questionnaire/Audit. Beginning 09/09/2022, the Social Worker will discuss with residents at Resident Council□s meeting abuse, neglect, dignity, resident□s rights, and importance of reporting those incidents. Beginning 09/09/2022 the Nursing Home Administrator will review audit documentation weekly for 30 days.	

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F 600	Continued From page 3 confirmed that CNA #1 was immediately removed from resident care and left the facility. CNA #2 confirmed she had participated in an investigation and completed a written witness statement. On 8/23/22 at 11:20 AM, an interview with CNA #3 revealed on 2/17/22, she heard Resident #1 yelling at CNA #1 and witnessed Resident #1 "swing at" CNA #1. She stated that she witnessed CNA #1 "kick the back of Resident #1's wheelchair and the force of the kick sent Resident #1's wheelchair rolling across the room and his right knee bumped into the wall. Record review of the Identification and Summary Sheet for Resident #1 revealed he was admitted by the facility on 3/26/21. He had diagnoses including Lewy body Dementia, Depression, and Mood Disorder. Record review of the Quarterly Minimum Data Set (MDS) with reference date (ARD) 6/30/22, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 3 out of 15. Record review of the employee file for CNA #1 revealed "License/Certification/Registration Renewal Verification," dated 5/20/21, confirmed CNA held current certification as a "Certified Nurse Aide." Review of the Nurse Aide Registry Verification dated 4/21/21 confirmed CNA #1 was originally certified on 3/30/21, as a Nurse Aide.	F 600	Beginning on 10/05/2022, the Nursing Home Administrator will report all audit findings to the Quality Assurance Performance Improvement (QAPI) committee monthly for action until consistent substantial compliance has been achieved as determined by the committee. Should systemic changes not be effective QAPI will investigate and will determine if further action(s) need to be implemented. The actions from QAPI meeting will be reported to the facility's Executive Committee.	