

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 A standard survey was conducted at the facility from June 10, 2019 through June 13, 2019. The standard survey revealed the facility was not in substantial compliance with the requirements for participation in Medicare/Medicaid. The following deficiencies resulted from the facility's noncompliance: F-584, F-604, F-636, F-656, F-658, F-660, F-679, F-880. The facility's census on June 10, 2019 was 47 residents and the facility held a license for 59 beds.	F 000			
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 584		8/6/19	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

08/05/2019

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 584	Continued From page 1 §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of facility policy, the facility failed to maintain a clean and comfortable environment for two (2) of two (2) facility residential units. The environmental tour on the Women's Unit identified numerous disrepair issues in the community bath and shower room. The environmental tour on the Men's Unit identified numerous areas with chipped and peeling paint; lack of privacy curtains in the community shower and toilet; and black type substance on shower floor. Findings include: Review of a facility document titled, "Mississippi State Hospital Whitfield, Mississippi 39193 JNH POL J530-26", dated December 2017, titled: "Monthly Building Inspection" documented the following:	F 584	a. How the corrective action(s) will be accomplished for those resident(s) found to have been affected by the deficient practice? Female side of facility " 6-12-19 o Shower Room Floor tile and grout were scrubbed, cleaned by facility housekeeping (HK) staff " 6-13-19 o o Shower Room – Navy blue mats were cleaned by facility HK staff. Manufacturer specification on mats were obtained from manufacturer product specifications that promote the mats as "Safety Walk" Wet Area Matting, to improve slip resistance and reduce falls. o Shower - Gray-black substance was removed from shower drain by facility HK " 6-14-19 o Toilet Room soap dispenser was		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 584	Continued From page 2 This policy is to outline the method utilized by Jaquith Nursing Home (JNH) to ensure the physical environment is well maintained and meets or exceeds regulatory standards. Policy: It is the policy of JNH to provide a safe and comfortable living environment for the residents in accordance with regulatory standards. The Coordinator of Unit Operations (CUO) are responsible for conducting a monthly building inspection to document any deficiencies and to assure that repairs are made timely. Environmental Tour of Women's Unit: Observation of the community bathroom on the Women's Hall, on 06/11/19 at 9:14 AM, revealed the following: Crumbling and, broken floor tile around the drain in the middle of the floor near the entrance to the showers. The broken tiles were one (1) inch by one (1) inch, and was loose and crumbling. The tiles moved with the weight of my foot on them. A wet floor sign was positioned behind the broken tile, but did not serve as a barrier to prevent someone walking over it. There were three (3) commodes on the right side of the Women's bathroom with hoses above the commodes. The hoses were stained dark brown to black with a dark substance. There was not a curtain for privacy between the two (2) commodes. There was one (1) toilet stall on the right side of the bathroom with a toilet seat that was stained yellow and light brown. The front of the base of the toilet in the stall was broken and jagged. If a	F 584	cleaned by facility HK " 6-15-19 o Shower Room leaking shower head was repaired by Mississippi State Hospital (MSH) Maintenance " 7-3-19 o Toilet Room long discolored tubing (hoses) running from rear of toilet into wall behind toilet was removed by MSH maintenance. On 8-2-19 the holes resulting from the removal of tubing was repaired by contract repair worker. o Toilet Rust and peeling paint was removed from the window ledge by facility HK. " 7-8-19 o Toilet Room One (1) of three (3) toilets was removed by MSH maintenance. Privacy partitions were put in place for the remaining two (2) toilets by MSH maintenance. On 8-2-19 the hole in floor resulting from toilet removal was filled by contract repair worker. " 7-30-2019 o Toilet Room Toilet with broken jagged base was replaced by MSH maintenance with new toilet. " 8-2-19 o Toilet Room Cracked glass pains in window were repaired by contract repair worker. o Toilet Room A contract repair worker completed repairs of drain in middle of floor by securing the drain, replacing tiles and filling gaps with self-leveling, bonding material.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 584	Continued From page 3 resident were sitting on the commode their heels could make contact with the broken base. The soap dispenser over the handwashing sink had a brown stain that appeared to be dry on the push handle that dispensed the soap. The sink nearest the outside wall appeared detached from the wall. (Grout separated from the sink). The sink did not move when touched because of brackets holding it up. There were soiled wet navy-blue mats in the floors of both showers that were not non-skid. There was a brown-black like substance in the floor grout of both showers, at the junction of the floor tile and the shower floors. The floors appeared wet as if they had been used for a shower. The shower drains were clogged with a gray-black sticky substance. Window ledges had rust and peeling paint. Interview and observation of the Women's Community Shower room floor, on 06/11/19 at 3:30 PM, with the Manager of the Carpenter Shop, who stated that this was his title, revealed the Manager of the Carpenter Shop stated he was also the Maintenance and Housekeeping Manager. The Manager of the Carpenter Shop Maintenance and Housekeeping Manager revealed that the bathroom should be repaired and cleaned. During the observation, the Manager of the Carpenter Shop/Maintenance and Housekeeping Manager stated that he would notify the plumbing manager to take care of	F 584	Male side of facility " 6-13-19 o Room 107 Large brown stain near foot of bed-A was cleaned, removed by facility HK " 7-3-19 o Toilet Room long discolored tubing (hoses) running from rear of toilet into wall behind toilet was removed by MSH maintenance. On 8-2-19 the holes resulting from the removal of tubing was repaired by contract repair worker. " 7-31-19 o Room 115 Entrance door frame (scuffed, blackened, chipped paint) was repaired by MSH painters o Toilet Room Wall vents were cleaned of dust and debris by facility HK " 8-2-19 o Toilet Room Gap between back of sink and wall was repaired by MSH maintenance. o Front, Main Hall, Men s side Chipped, peeling paint below hand rail was repaired by MSH painters o Toilet Room Cracked tile at base of window was repaired by contract repair worker. o Men s hall (rooms 111 to 136) Marks and peeling paint on walls and door jams in hallway were repaired by MSH painters o Men s Hallway Scrapped area, approximately 18 feet long, under handrail was repaired by MSH painters. o Men s Back Hallway Eight (8) areas of scrapped paint were repaired by MSH Painters " 8-3-19		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 584	Continued From page 4 plumbing issues. The Manager stated he would have to determine from administration whether there were bids for replacing the windows in the bathrooms. The Manager noted the following: Floor needed immediate repair. Hoses behind the commodes should be removed or repaired. There should be a privacy curtain between the two commodes. The toilet seat should be replaced. Soap dispenser should be cleaned. The blue pads in the shower floors should be replaced with non-skid pads. The shower floor-wall grout should be cleaned. The windows should be totally replaced. Observation of the Women's Hall Community Bathroom and Shower room was conducted with the Quality Assurance (QA) Registered Nurse (RN), on 06/13/19 at 11:50 AM. The QA RN took notes of the soiled commode seat, the soiled hoses on the wall behind the commodes. The lack of a privacy curtain between two (2) commodes. The black grout in the floor of the showers, the rusty window pane frames with paint peeling off them. The QA RN stated she would inform the Quality Assurance Performance Improvement (QAPI) committee of the findings. Observation of the Women's Hall Community Bathroom and Shower room was conducted with the Administrator, on 06/13/19 at 4:00 PM. He stated that he was unaware of the state of disrepair of the bathroom and shower room. He stated that rounds are made by the staff to determine repairs that must be made. Those reports are turned in as work orders. The Administrator stated that repairs should be made to the Women's bath and shower rooms and added, "You should have shown me first."	F 584	o Toilet Room Broken window glass (panes) were replaced by contract repair worker " 8-5-19 o Room 107 Blackened, chipped and peeling paint to entrance door was repaired by MSH painters " 8-6-19 o Day Room The 18 inch, scrapped paint area will be repaired by MSH painters b. How will you identify other residents having the potential to affected by the same deficient practice, and what corrective actions will be taken? All residents of facility have the potential to be affected by same deficient practice. On July 31, 2019 Coordinator of Unit Operations (CUO) in-serviced the facility housekeeping (HK) staff on Mississippi State Hospital s (MSH) Environmental Services (ES) policy 191-30 and procedures. These procedures included, cleaning of vents, floor, restrooms, patient/resident rooms, shower and bath rooms and proper cleaning cart set up. On August 1, 2019 the Nursing Home Administrator (NHA) conferenced the CUO on ensuring that HK make diligent efforts to clean the areas listed in the policy. c. What measures were put in place or what systemic changes will you put into place to make sure that the deficient practice does not reoccur? Beginning August 1, 2019 the facility CUO will make inspection rounds of the facility two (2) times per week. The CUO will		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 584	Continued From page 5 Environmental Tour of Men's Unit (Rooms #107, #115 and Community Bath/Shower Room) An environmental tour on the front hall of the facility's unit where male residents resided was conducted, on 06/13/19 at 10:38 AM, with the Coordinator of Unit Operations (CUO). Areas of concern were maintenance of the physical plant that were identified during the tour and included: Front/Main hallway: Chipped/peeling paint on right side of wall, approximately two (2) and one-half (1/2) feet above the floor and just below the handrail. The CUO stated this was probably from staff pushing residents in a geri-chair down the hallway, hitting the arm of the chair on the wall. The CUO stated this wall had been painted approximately six (6) months previously. Room 107A: The entrance door and doorframe were scuffed and blackened, with paint chipped and peeling off in areas up to approximately two (2) feet from the floor. A large (approximately 12 inches by six (6) inches) brown stain was noted on the tiled floor at the foot area of Bed A. This stain was first noted on 06/10/19 at 4:20 PM, and continued to remain on the floor during the 06/13/19 tour with the CUO. When brought to the attention of the CUO she asked a staff person to get cleaning supplies and try to remove the stain. The staff person did this and the stain was removed. When questioned regarding why the stain had been observed to remain on the floor of the resident's room for over three (3) days, the CUO responded that staff may have thought it couldn't be cleaned up. Room #115: The entrance door and doorframe were scuffed and blackened, with paint chipped and peeling off areas up to approximately two (2)	F 584	identify repair and cleaning needs. Needs identified will be recorded on the ES checklist. Actions taken to correct needs identified will be recorded in the comments section of the checklist. The CUO will continue these inspections rounds until December 31, 2019. On January 1, 2020 the CUO will begin conducting two rounds per month. On August 2, 2019 the facility was divided into quadrants and the quadrants were identified and explained to the HK staff. A HK staff will be assigned to each quadrant daily and the assigned staff will be responsible for ensuring cleanliness and also identifying and reporting repair needs to the CUO. Examples of needs will include window glass, paint on walls and doors, floors and floor tiles, bathroom fixtures, furniture and lights and fixtures. d. How will the corrective action be monitored to ensure the deficient practice will not reoccur? What quality assurance program will be put in place? The facility NHA will accompany the CUO one (1) inspection round per month. The CUO will report monthly to the NHA work orders issued to MSH maintenance department for repair needs and a summary of the identified items recorded on the ES checklist. The CUO will report the summary of work orders and identified repair needs and repair status to the facility Quality Assurance and Performance Improvement committee every other month. The MSH ES Director or designee will conduct quarterly inspection rounds on the facility. The ES Director will assess cleanliness and repair		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 584	Continued From page 6 feet from the floor. Men's toilet room: The room contained three (3) toilets that were separated by stall doors. A long, tubing, rusted and stained with a brownish substance, was noted attached to the wall beside each of the three (3) toilets. The CUO acknowledged the three (3) tubing devices were rusty/dirty and stated they were no longer functioning, but in the past had served as a Bidet. The vent to the outside from this bathroom is noted to be filled with dust/debris. There are two (2) windows in this bathroom. The paint on each was noted to be peeling with rust all around the metal parts. The tile at the base of the windows was cracked where they had been cemented in the past. There was cracked panes of glass. The CUO stated the windows were made of steel and are not replaceable. The CUO stated during the environmental tour, the facility is located on a campus that contains six (6) nursing home buildings and numerous buildings that provide a variety of services. However, the campus only has four (4) qualified painters to maintain each of the buildings on campus. The Administrator was interviewed, on 06/12/19 at 8:30 AM, regarding the facility environment. The Administrator indicated the facility did not have a specific policy related to how the facility should be monitored and maintained. The Administrator stated there was no set standard for who monitors the facility for maintenance issues such as painting, etc. The Administrator stated he did walk around the building and if he saw anything a work order for repairs would be submitted. The Administrator stated the facility did have contractors on staff who were responsible for painting and repairs. The facility	F 584	needs and record identified needs on the MSH ES checklist. MSH accreditation and licensing staff will conduct monthly inspection rounds on the facility and also assess cleanliness and repair needs. Accreditation and licensing staff will report the monthly findings to the NHA.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 584	Continued From page 7 used to have six (6) to eight (8) people responsible for that, but there had been cut backs, and now only had three (3) to four (4) contractors responsible for the entire campus. Following the interview with the Administrator, he provided a copy of the facility's repair work orders, entitled, "MSH Maintenance Work Order Request." A review of the work order revealed there were various items on the list submitted for repair. The list identifies those items that have been completed and the items that are "issued to shop" and are still pending repair. However, a comparison of the list on 06/13/19 with the environmental concerns identified during the survey dates (06/10 - 13/19) revealed the concerns identified on the survey had not been added to the pending repair work orders. Environmental Tour of Men's Unit (Rooms #111 to #136) Observation, on 06/09/19 at 1:30 PM, during the facility tour on the male hall of cognitively impaired residents residing in rooms #111 to #136 revealed the following: Marked, and peeling paints on the walls and door jams throughout the hallways. The back hall from the dining room to the men's hall revealed three (3) large eight (8) inch areas of paint scraped off the wall on the right side. The men's Day Room had a 18 inch area of paint scraped off the wall on the right side. The peeling paint was the latex peeling from paint over the enamel on the walls with no paint flecks on the floor.	F 584			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 584	Continued From page 8 The hallway leading down to the men's rooms had scrapes of paint missing under the handrails on the left side of the length of the hall, approximately 18 feet in length. Each door frame entering Rooms #111, #113, #115, #117, #119, #122, #136, and #138, had paint missing and with multiple scrapes on each of these doors and door frames. There were black marks under where the paint was missing on the entrance, entering these room of the door frames. The Maintenance Manager stated, "These are black marks from scuffing objects against the doors." An additional tour of the male hallway rooms and shower room with the Maintenance Manager, on 06/12/19 at 10:20 AM, revealed the following: During the observation, the Maintenance Manager confirmed the door jams to the room entrances had peeling paint, scraped off paint with dark marks, and in disrepair in Residents #23, #119, #34, #138, #37, #112, #41, #117, #43, #117, #17, and #136's rooms. The Maintenance Manager stated, "These are black marks from scuffing objects against the doors." In these rooms that were entered and observed, there was paint peeling off the walls, window sills and window frames with rust and chipped paint. The paint on the walls in the hallway on both sides was scraped under the handrail the length of the hallway. The male shower room and the whole back wall, four (4 feet) from the ceiling and 16 feet in length, had a black substance across this wall. The Maintenance Manager stated and confirmed the presence of the black substance and stated, it appears that we need another	F 584			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 584	Continued From page 9 exhaust fan in this shower room, as well as painting." Interview with the Maintenance Manager, on 06/12/19 at 10:20 AM, confirmed the paint on the walls and doors was latex paint, and had been painted over the previous enamel paint. Interview, on 06/12/19 at 1:45 PM, with the Coordinator of Unit Operations, who was responsible for overseeing the maintenance and housekeeping in the building stated, 15 years ago the facility was using enamel paint inside for painting, then a year or two (2) later they started using latex to paint over the enamel. Even I know, that latex will not bond and seal over enamel, that's why its chipping, peeling and wearing away.	F 584			
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 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.	F 604		8/6/19	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 604	Continued From page 10 §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, record review, and review of facility policy, the facility failed to use physical restraints in circumstances where the residents had medical symptoms that warranted the use of restraints for three (3) of 32 residents reviewed. Resident #12, Resident #21 and Resident #36 were each identified as being physically restrained in the absence of clinical documentation of on-going assessment and re-evaluation, care planning, and/or supporting evidence the restraint was the least restrictive means necessary to treat a physical or psychological condition. Resident #12 and Resident #36 were each restrained in a pelvic restraint in the absence of assessment for the device use, re-evaluation for continued restraint use, and the development and implementation of interventions for reducing or eventually discontinuing the use of the restraint. Resident #21 was observed during the survey in in pelvic/trunk restraint. The facility was unable to provide documentation of an initial restraint	F 604	1. How the corrective action(s) will be accomplished for those resident(s) found to have been affected by the deficient practice: Resident s # 12, 21, and 36 were assessed by the facility Director of Nursing Services (DON) on June 13, 2019 to verify the appropriate need and safety risks associated with the use of restraints. The Director of Nurses met with the Interdisciplinary team (IDT) and facility physician on June 13, 2019 to discuss the appropriate need for restraints for resident s # 12, 21, and 36. The Restraint Reduction assessment was updated on resident s #12, 21, and 36 by the Minimum Data Set, (MDS) nurse on 6/13/19. The physician gave orders to discontinue the restraints on resident #12 and #21. Resident s # 12 and 21 care plans were updated and the representative was notified upon completion of the restraint reduction assessment and of new orders by the MDS nurse on June 13, 2019.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 604	Continued From page 11 assessment to identify the use of a pelvic restraint; or ongoing assessments for the continued use of the pelvic restraint; a physician's order for the use of the restraint; or attempts to use the least restrictive type of restraint. Findings include: Review of the facility's policy entitled, "Restraints", (revised May 2019) revealed a policy statement that each resident has the right to be free from any physical or mechanical restraint imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. The policy defined a physical restraint as any manual method or physical or mechanical device, material, or equipment attached or adjacent to a resident's body, which the individual cannot remove easily, and that limits freedom of movement or normal access to one's body. The policy went on to identify a list of devices that could be considered restraints. Some devices in the list included: limb restraints, pelvic holders, chair lap trays, side rails, geriatric chairs, seat belt, and sleeved jacket/vest. Continued review of the restraint policy revealed procedures for the use of physical restraints had been outlined. The policy procedures stated alternative therapeutic interventions will be attempted prior to use of restraint devices. Therapeutic interventions such as pillows, pads, removable lap trays, meaningful activity, environmental changes, and assertive nursing rehabilitation or restorative programs are examples of less restrictive methods of meeting a resident's needs. Consultation with health professionals, i.e., treatment team members, physical therapist, occupational therapist, will occur in the use of less restrictive supportive	F 604	On July 29, 2019 the IDT met and discussed the restraint reduction on resident #36. The physician ordered to discontinue resident # 36 s restraint in bed. Resident #36 s care plan was updated and the representative was notified upon completion of the restraint reduction assessment and of new orders. 2. How the facility identified other residents having the potential to be affected by the same deficient practice: On June 13, 2019 the facility MDS nurse and facility DON reviewed the Resident s Roster Matrix and identified five (5) other residents that have the potential to be affected by the same deficient practice. Corrective actions were taken and Restraint assessments and care plans were updated on these five residents by the MDS nurse and DON on 6/13/19 and 6/14/19. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: An in-service education program on the facility Restraint and Resident Right s policy and procedures was conducted by the Director of Nursing Services on June 12 and June 13, 2019 with all direct care staff addressing appropriate needs that require the use of restraints and the hazards associated with their use. Newly hired nurses will continue to be in-serviced/educated on the facility Restraint and Resident Right s policy and procedure during orientation. Jaquith Nurse Administrator met with the facility physician on 6/13/19 to discuss the		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019	
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN				STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 604	Continued From page 12 devices prior to using physical restraints. The policy procedures documentation stated when a nurse determines a restraint device is necessary to enable a resident to attain or maintain his/her highest level of functioning, the nurse will document on the initial/annual assessment his/her assessment. The written assessment will include: 1. Resident's history; medical conditions that place residents at risk for life threatening falls; and/or medical symptoms that led to the consideration of the use of restraints. 2. The resident's behavior, e.g., self-injurious, combative, agitated, aggressive toward others. 3. Above risk factors that may be eliminated or reduced. 4. Any alternatives to restraints previously attempted. 5. The resident's response to restraint alternatives. 6. Any consultations by behavioral health services, occupational therapy, kinesiotherapy, or physical therapy. 7. Recommended least restrictive restraint devices. 8. When the restraint device is needed. 9. Benefits associated with the use of the restraint. 10. Risk factors associated with restraint use and approaches toward elimination of restraints or less restrictive device addressed on the care plan. The nurse will notify the physician of the nursing assessment and the physician will determine if a restraint device is needed based upon the nurses' assessment. Application of the restraint device will require a physician's order which includes the type of restraint, the reason for use of the restraint, duration of use, with checks and releases per facility policy. The need for restraints will be re-evaluated by the treatment team at least monthly with resident assessment updates and efforts to limit their use will be tried and documented. Resident #12			F 604	Federal regulation Ftag 604. She reviewed with the facility physician that falls do not constitute self-injurious behavior or a medical symptom that warrants the use of a physical restraint. They discussed alternative therapeutic interventions to use instead of restraints such as, removable lap trays, meaningful activities, therapy and pillows. Jaquith Nurse Administrator discussed with the medical director education material on the Federal regulation Ftag 604 on 6/26/2019. 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. This POC is integrated in the QA system. The Director of Nursing Services, or Registered Nurse staff, will conduct a random audit of five (5) residents weekly for four (4) consecutive weeks. These residents will be assessed and interviewed/observed to ensure the appropriate reasons for use of restraints are properly identified, evaluated, documented and care planned. Findings of this audit will be discussed with the Nursing Home Administrator, (NHA.) and the Medical Director. The NHA will report findings, the progress and effectiveness of the corrected actions to the Quality Assurance Performance Improvement (QAPI) committee meeting each month. Should systemic changes		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 604	Continued From page 13 Resident #12 was observed, on 06/10/19 at 12:25 PM, to be in the dining room, seated in a wheelchair, positioned at a table. The resident was observed to have a pelvic restraint in place that was tied in the back to each of the anti-tip bars of the wheelchair. Resident #12 was observed to use both hands to pull on the pelvic restraint, pulling it away from his pelvic area. The resident was unsuccessful in removing the device from his pelvic area. Resident #12 was again observed, on 06/11/19 at 12:32 PM, to be in the dining room. The resident was seated in a wheelchair with a pelvic restraint in use. Resident #12 was observed, on 06/12/19 at 10:30 AM, seated in a wheelchair in the dining room. The resident was attending a group activity. The resident had a pelvic restraint in place. The restraint device was observed to have a mesh type material at the resident's pelvic area, went around the resident, and was tied to the anti-tip bars of the wheelchair the resident was seated in. The pelvic device was secured in a manner that prevented the resident from standing or slipping out of the wheelchair. Review of the medical record revealed Resident #12 was assessed on an Annual Minimum Data Set (MDS) assessment, dated 03/25/19 to have a Brief Interview for Mental Status (BIMS) score of 14, indicating independent cognitive skills for daily decision making. The MDS assessment identified the resident with diagnoses that included Dementia, Parkinson's disease, and Depression. The assessment identified Resident #12 to have exhibited physical and verbal	F 604	not be effective, QAPI committee will investigate and determine further action(s) to be implemented. The corrective action will be completed on August 6, 2019.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 604	Continued From page 14 behavioral symptoms directed toward others for one (1) to three (3) days during the assessment review period. The assessment indicated the exhibited behavioral symptoms did not put Resident #12 or other residents at significant risk for physical injury. The resident was assessed to be independent, with no staff assistance or oversight, in transfers and locomotion on/off the unit and had experienced no falls during the assessment review period. Resident #12 was assessed as not being steady when walking, but was able to stabilize without human assistance. The resident had no functional limitations to upper or lower extremities with range of motion (ROM). The assessment identified that there were no physical restraints used for Resident #12 during the review period. Behavioral symptoms and falls triggered for further review utilizing the Care Area Assessment process. Review of the Physician's Orders for Resident #12 revealed the resident had a restraint order, dated 03/11/19 that specified: Restraint order: Pelvic restraint while in geri-chair (geriatric-chair) for safety/positioning x 30 days. Release/reposition every two (2) hours with circulation checks every 30 minutes. Diagnosis: Lewey Body Dementia (Protein deposits, called Lewey Body, develop in nerve cells in the brain regions involved in thinking, memory, and movement/motor control). Continued review of the physician's orders revealed the pelvic physical restraint order had been an on-going monthly order since before July 2018. Review of the medical record for Resident #12 revealed an "Initial/Annual Restraint Assessment" was documented and signed by the attending physician and members of the Interdisciplinary	F 604			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 604	Continued From page 15 Treatment team (IDT). However, the restraint assessment was not dated. The IDT did document that quarterly reviews were conducted of the initial/annual restraint assessment as evidenced by noted "Quarterly Restraint Evaluations" being documented and signed by members of the IDT on 07/9/18, 10/11/18, and 01/15/19. There were no further quarterly restraint assessments completed after the assessment done on 01/15/19. When evaluating the need for physical restraint, the Initial/Annual restraint assessment included Resident #12 had a history of falls due to an unsteady gait; was not easy to redirect, with aggression and agitated; no alternatives to restraints had been tried, the resident was cooperative at this time, a pelvic restraint was recommended when in a geri-chair; benefits associated were to prevent and decrease falls and; the care plan addressed risk factors and approaches toward elimination or less restrictive devices. Review of each documented "Quarterly Restraint Evaluation" on 07/9/18, 10/11/18, and 01/15/19 revealed the pelvic restraint was recommended to be continued and the reason for the recommended restraint was for "safety." The "Quarterly Restraint Evaluations" did not include evaluation of least restrictive measures being tried or consideration of the potential to reduce/eliminate the physical restraint use. In addition, the restraint evaluations did not consider that placing Resident #12 in a geri-chair and a pelvic restraint at the same time had the potential to create double restraints for the resident. Review of the Care Plan, for Resident #12, revealed a risk for falls was identified on 05/15/17, with a review date of 03/10/19. The fall risk was identified as being related to dementia;	F 604			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 604	Continued From page 16 unsteady gait; side rails; geri-chair; pelvic restraint; and Parkinson's. The goal established to address the resident's risk for falls stated, "Resident will be free of falls." Although the use of a geri-chair and pelvic restraint were assessed as potential contributors to the resident's fall risk, there were no interventions planned to direct staff regarding the use of the devices to decrease the risk for falls. The interventions did include "Up in geri-chair as tolerated." There was no mention of the use of a pelvic restraint in the planned approaches/interventions. Continued review of the Care Plan revealed restraint use was identified as a problem deficit on 07/11/17 and last reviewed on 03/10/19. The problem statement indicated the resident used a pelvic restraint while in geri-chair for safety, and the resident removed the restraint and stood up without assistance, frequently. However, the Care Plan documentation reflected, on 03/20/19, the problem of restraint use had been marked out and a note made that stated, "Resident ambulatory not in restraint has wander guard." A second notation on the restraint Care Plan, dated 04/18/19, stated, "Restraint D/C (discontinued)." Resident #12 was observed throughout the survey dates (6/10 - 13/19) to be up in a wheel chair with a pelvic restraint in use. There was no evidence the facility had developed and initiated a care plan outside of the discontinued plan to address the resident's on-going use of a pelvic restraint. Review of documentation titled, "Physical Therapy Plan of Care", revealed Resident #12 was evaluated and physical therapy services initiated on 01/29/19. Treatment diagnoses for the resident included abnormalities of gait and mobility, lack of coordination, abnormal posture,	F 604			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 604	Continued From page 17 weakness, and history of falls. Short-term goals were established to improve each treatment diagnosis with a goal date of 03/12/19. Long-term goals were established, with a goal date of 03/25/19, for the resident to have complete bed mobility with modified independence and functional transfers with modified independence. An ambulation goal of 300 feet with a rolling walker with modified independence was also established. The plan of care specified Resident #12's rehabilitation potential was good due to his being an independent ambulator prior to onset of an unsteady gait. The physical therapy documentation did not reflect the end of care date for discontinuation of therapy services for Resident #12. Review of Nursing Notes, documented on 03/20/19, revealed a physical therapist brought Resident #12 back to the unit, and stated she was discharging the resident from therapy services due to the resident fighting. The nursing notes indicated the resident had a firm grip on the therapist's bag and would not release it. The resident was attempting to kick staff and swing his arms/fists. An interview was conducted, on 06/13/19 at 8:30 AM, with Physical Therapist (PT) #7, who provided therapy services for Resident #12. PT #7 stated the resident received physical therapy in January 2019 with a goal to get him independent in ambulation. Prior to initiating physical therapy, staff got the resident up into a geri-chair and applied a pelvic restraint, however, the resident could ambulate with some unsteadiness. PT #7 stated the resident did succeed in getting stronger with therapy by	F 604			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 604	Continued From page 18 gaining strength in balance and control. PT #7 stated her main goal with Resident #12 was to get him out of the restraint to ambulate independently. Ultimately the goal was met, however, due to the resident's behaviors the facility staff had to resort to the restraint. PT #7 confirmed the documentation in the nursing notes, dated 03/20/19, regarding Resident #12's combativeness and ultimate discharge from physical therapy. PT #7 added that upon return to the unit staff had placed a pelvic restraint on the resident while in a wheelchair. However, review of the nursing notes revealed this had not been documented. PT #7 indicated she did not know the resident's current ability related to ambulatory status since discharging him from physical therapy. PT #7 stated upon discharge from physical therapy services an "as needed" recommendation for kinesiology services (facility's restorative program) was made. According to PT #7 this recommendation meant if the nurses identified a need for the resident to receive restorative services they had the option of requesting a physician's order for the services. An interview was conducted, on 06/10/19 at 12:25 PM, with Resident #12. The resident was observed to be in the dining room in a wheelchair with a pelvic restraint in place. When questioned regarding the device, Resident #12 stated, "They put the device on me to keep me from getting up." The resident stated he did not like it. When asked if he had told staff he didn't like it, Resident #12 stated he had told them, but they didn't care. An interview was conducted with Resident #12, on 06/12/19 at 10:30 AM. The resident was seated in a wheelchair, in the dining room where a group activity was being conducted. The	F 604			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 604	Continued From page 19 resident continued to have a pelvic restraint in place. When questioned again about the restraint device the resident stated the staff put it on him because they don't trust him. Resident #12 further indicated he could get up and walk when the device was not on him. The resident went on to state he could remove the restraint and had done it a few times when staff were not looking. When asked how he could remove it the resident started to demonstrate that he could pull his legs/feet up and through the holes/spaces and slip the restraint down. The surveyor asked Resident #12 to not continue trying to remove the restraint and the resident complied. The resident went on to state that when staff see that he has slipped out of the device without assistance they made him sit back down in the wheelchair and reapplied the restraint device. An interview was conducted with Certified Nursing Assistant (CNA) #2, on 06/12/19 at 1:47 PM. CNA #2 stated she was assigned to provide care for Resident #12. CNA #2 stated when the resident got up in the morning he was assisted to the wheelchair, and a pelvic restraint was placed on the resident. According to CNA #2 the resident was checked every 30 minutes for restraint placement, and released/repositioned every two (2) hours. This was confirmed through a review of the documented Activities of Daily Living (ADL) flow sheet for Resident #12 for the months of May and June 2019. CNA #2 stated the resident was a fall risk and the nurses did not want him walking around. According to CNA #2 the resident could weight bear and could walk by himself, but not for long periods. CNA #2 stated she had been given no instructions to remove the pelvic restraint and walk with the resident when assigned to care for him. The CNA posed the	F 604			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 604	Continued From page 20 question, "What if we are walking with him and he has an episode?" CNA #2 stated she also worked on the night shift and there was a nurse who sometimes got the resident up and walked with him. CNA #2 denied having ever seen Resident #12 remove the pelvic restraint by himself. CNA #2 stated the resident would sometimes say, "I don't need this thing" or "My doctor said I don't need this thing today." when they went to put the pelvic restraint on him. According to CNA #2, there had been an incident a few months previously where Resident #12 started walking away when the pelvic restraint was released. CNA #2 stated it took four (4) staff persons to get the resident back into the wheelchair and the pelvic restraint reapplied. When questioned regarding whether the staff had tried to walk with the resident instead of placing him back into the chair and restraint, the CNA indicated they had not let the resident walk. Resident #12 was placed back in the chair and the restraint applied. An interview was conducted, on 06/12/19 at 2:35 PM, with Licensed Practical Nurse (LPN) #1, who was assigned to provide care for Resident #12. LPN #1 stated if staff removed the pelvic restraint from Resident #12, the resident could definitely get up and walk. According to LPN #1, the main reason for the restraint use was due to the resident rummaging through the property of other residents. LPN #1 stated that previously when the restraint was removed, Resident #12 would roll his wheelchair up to another resident's room, stand up, and wander into the room. This caused a big problem. The pelvic restraint had to be reapplied. LPN #1 stated she knew the CNAs removed the restraint, but didn't know if they left it off or put it back on. LPN #1 stated nursing staff	F 604			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 604	Continued From page 21 does not walk with the resident. According to LPN #1, the resident was going to therapy, but it had been discontinued because Resident #12 was aggressive. LPN #1 was not aware of a restorative program to continue to walk with the resident. An interview was conducted, on 06/12/19 at 2:47 PM, with Registered Nurse (RN) #3, a unit floor nurse where Resident #12 resided. RN #3 stated the resident could become combative with staff, and required the use of a pelvic restraint when up in a wheelchair. According to RN #3 the resident could ambulate independently with an unsteady gait. RN #3 stated Resident #12 had recently received physical therapy for ambulation. When a resident is discontinued from physical therapy there is no plan developed to provide a resident with continued services. Nursing staff just start doing some things to ensure a resident continues to walk or exercise. There had been no formal plan developed for Resident #12 to continue with an ambulation program. RN #3 was unaware of a recommendation for a referral to kinesiology for restorative services for Resident #12. An interview was conducted with Certified Nursing Assistant (CNA) #8, on 06/13/19 at 1:52 PM. CNA #8 stated she did on occasion apply the pelvic restraint to Resident #12 when up in a wheelchair. CNA #8 indicated in the past the resident couldn't walk, and would try to get up when seated in a geri-chair. CNA #8 stated Resident #12 must have fallen causing the staff to start putting him in a pelvic restraint. According to CNA #8, she had seen the resident up walking into other resident's rooms taking their personal things, about a month previously. Because he would become combative the pelvic	F 604			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 604	Continued From page 22 restraint was reapplied. CNA #8 stated Resident #12 could walk, and she thought the restraint could be "holding him back." CNA #8 confirmed she had received training from the facility in proper application of restraint devices, indicating this was an annual training for all nursing staff. An interview was conducted, on 06/12/19 at 3:09 PM, with a Mental Health Recreation Therapist (MHRT) who worked with the activity department. The MHRT stated her responsibilities included assessing residents for individualized interests and providing an activity program, along with other activity staff, to residents in the facility. The MHRT stated when Resident #12 and other residents attend group activities with a physical restraint in place the restraint is not removed while the residents participate in the activity. According to the MHRT the nursing staff do not remove a resident's physical restraint during activity participation because it is there for the resident's safety. An interview was conducted, on 06/13/19 at 12:09 PM, with the attending Physician who provided services for Resident #12. The Physician stated the resident had received physical therapy services, and did show improvement in ambulatory abilities. The physician gave an order for the physical restraint to be discontinued. However, this failed as the resident would wander into other resident's rooms and take their things. This lasted for a few days, and the order was given to continue with the physical restraints. The Physician stated in addition, the resident wasn't sitting in the chair properly and was falling. According to the Physician, if a resident had a history of falling or behaviors against other residents, other things may be tried, but physical	F 604			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 604	Continued From page 23 restraints were used if nothing else worked. The Physician could not identify what other interventions were tried before Resident #12 was placed into physical restraints. The evidence supports Resident #12 was physically restrained without thorough assessment of a medical or psychological need, to include a determination of a least restrictive device. On-going re-evaluation of the use of a physical restraint was not conducted, in an attempt to reduce or eliminate restraint use, and a care plan was not developed with interventions to prevent and address any risks related to the use of the restraint. Resident #21 Health record review indicated that Resident #21 was admitted into the facility on 12/01/2008, and readmitted into the facility on 11/30/2015. Resident #21's diagnoses included, but were not limited to Schizoaffective disorder, Bipolar disorder, Thyroid Disorder and Recurrent Urinary Tract Infections. Review of the Annual Minimum Data Set (MDS) assessment for Resident #21, dated 10/22/18, revealed a Brief Interview Mental Status Score (BIMS) of 8, which indicated a moderately impaired cognitive status. Resident #21 had no behaviors during this assessment period. Review of Resident #21's functional status indicated that she required limited assistance of one (1) staff for bed mobility and transfers. Resident #21 was totally dependent on one (1) staff for locomotion on and off the unit. Additionally, Resident #21 was totally dependent one (1) staff for dressing,	F 604			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 604	Continued From page 24 toileting, personal hygiene and bathing. Resident #21 had no impairment of her upper and lower extremities. Resident #21 had no pain and no falls during this assessment period. Restraint review indicated that Resident #21 had trunk restraints while in chair or in bed daily. Review of the Care Area Assessment Summary (CAAS) for the Annual MDS, dated 10/22/18, revealed a care plan decision for, restraints. Review of the Quarterly MDS Assessment for Resident #21, dated 01/21/19, revealed a BIMS score of 5, which indicated severe cognitive impairment. Resident #21 had no behaviors during this assessment period. Functional status review indicated that Resident #21 required limited assistance of one (1) staff for bed mobility and transfers. Resident #21 was totally dependent for mobility on and off the unit. Resident #21 was also totally dependent for dressing, toileting, personal hygiene and bathing. Resident #21 had no impairment of her upper and lower extremities. Resident #21 had no falls. Trunk restraints were used day and night for Resident #21. Review of facility document titled "Informed Consent for use of Restraint Devices" for Resident #21, dated 06/12/17 and 07/30/18, revealed it was received by telephone and signed by two Registered Nurses (RN). Review of the "Mississippi State Hospital Nursing Assessment" for Resident #21, dated 12/5/18, indicated Resident #21 had no social behaviors. Resident #21 was at high risk for falls. There was no documentation of restraint use in the nursing assessment. The facility was unable to	F 604			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 604	Continued From page 25 provide documentation continuous assessments for the continued use of the pelvic restraint. The facility was unable to provide documentation of attempts to use the least restrictive type of restraint. Review of the "JNH Minimum Data Set Assessment Notes" for Resident #21, dated 04/6/19 to 04/12/19, revealed: Restraints-pelvic restraint always while in bed/Geri-chair. Behaviors-none. Falls-none. Review of the current Care Plan, dated 04/12/19, revealed plans that included: Risk for falls and injuries related to immobility and restraint (Pelvic) Usage. Pelvic restraint always while in wheelchair, in Geri-chair/wheelchair and bed. Approaches included circulation checks every 30 minutes and release and reposition every two (2) hours with Range of Motion to extremities for 15 minutes. Review of the Physician's monthly orders for April, 2019 lacked an order for the resident's pelvic restraint. An observation revealed, on 06/11/19 at 10:45 AM, Resident #21 was seated in a geri-chair in a slightly reclined position, 45-degree angle, with a pelvic restraint. Resident #21 was sitting quietly in the Women's Day room. An observation revealed, on 06/12/19 at 1:50 PM, Resident #21 along with seven (7) other residents in the Women's Day Room. Resident #21 was in the pelvic restraint in a geri-chair. An interview and observation, with Certified	F 604			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 604	Continued From page 26 Nursing Assistant (CNA) #9 in the Women's Day room, on 06/12/19 at 2:00 PM, revealed the residents are released from restraints and toileted every two (2) hours. An observation at this time revealed Resident #21 was transported away from the Day Room, and into her room for incontinent brief change. The pelvic restraint was tied properly with quick release loops. CNA #9 demonstrated the release of Resident #21's restraint. Resident #21's pelvic restraint was removed for the brief change. An interview with the facility's Physical Therapist (PT), on 06/13/19 at 8:56 AM, revealed Resident #21 was very impulsive with her movements. The PT stated Resident #21 often reacts to things in her mind, and could be impulsive and actively moved around. The PT states, "Makes you go into that gray area." The PT also stated PT "can handle walking with her." The PT stated that she was not certain that the nurses can handle the resident. The PT described Resident #21 as "one for us to build upon." The PT stated that Resident #21 would more consistently follow commands. The PT stated that she has worked here since November 2017, but still new to some of the decision making for restraint assessments. The PT stated that she had not participated in Resident #21's MDS assessments. An interview with the Attending Physician, on 06/13/19 at 12:09 PM, revealed that regarding restraints all or most of the residents in restraints have had dementia with behavior issues. The Physician said over time their conditions have deteriorated. The Physician revealed many of the residents have had recurrent falls, many have had seizures, many are in geri-chairs due to dementia. Physical therapy unsuccessfully	F 604			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 604	Continued From page 27 attempted to improve their strength. The ladies try to scoot out of the geri-chairs. The Attending Physician stated that another reason for the restraints was the residents attempted to scoot out of the geri-chairs. The Attending Physician described the regression from walking to restraints as: Walk independently. Walk with walker. Walk with merry walker. Try wheelchair or Geri-chair. Specifically, regarding Resident #21 the Attending Physician stated Resident #21 moved constantly. The Attending Physician also stated the resident spoke incoherently. When someone talked to her, Resident #21 reacted as if she thought they had accused her of something. Resident #36 Resident #36 was observed, on 06/13/19 at 3:39 PM, in the unit day room, seated in a reclined geri-chair. The resident did appear to be alert, and made eye contact when spoken to. However, the resident did not respond to verbal stimuli. During the observation a CNA was noted to walk behind the resident, and begin to push the resident in the geri-chair out of the room and down the hallway. At 3:47 PM Resident #36 was observed to continue to sit in the reclined geri-chair in the dining room where an ice cream and cake social was taking place. The resident had been served cake and a beverage with a straw in it. At 4:13 PM the resident was observed to have eaten 100 percent of the cake and drank the served beverage. Review of a Quarterly Minimum Data Set (MDS) assessment, dated 05/10/19, revealed Resident #36 was assessed with a Brief Interview for Mental Status (BIMS) score of 15, indicating	F 604			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 604	Continued From page 28 independence in daily decision making. The assessment indicated the resident required the total assistance of two (2) persons with bed mobility and transfers and was non-ambulatory. Diagnoses included Dementia, Traumatic Brain Injury (TBI), and Hemiparesis. Resident #36 had experienced no falls during the assessment review period. The resident was assessed to have utilized a trunk restraint daily. Review of a Physician's Note, dated 08/28/18, revealed documentation Resident #36 was found on the floor with face down, earlier in the morning, with a laceration at the right eyebrow. The Physician documented to prevent further falls, education of the resident; put a landing mat beside bed; start a pelvic restraint while in bed; and watch closely were ordered. Continued review of Physician Progress Notes revealed, on 09/13/18, the Physician documented because of the resident's PICA (psychological disorder characterized by an appetite for non-nutritive substances) and behavioral problems the resident needed a special geri-chair and required a pelvic restraint while in bed because of a recent fall. Review of Physician's Orders revealed Resident #36 had received orders for the use of a pelvic restraint when in bed since the fall incident documented on 08/28/18. The most current physician's order was dated 06/10/19, and stated: Restraint Order: Pelvic restraint while in bed for safety/fall prevention x 30 days. Release/reposition every two (2) hours with circulation checks every 30 minutes. Diagnosis: Anoxic Brain Injury/Vascular Dementia. Review of the Care Plan, dated 08/28/18, for	F 604			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 604	Continued From page 29 Resident #36 revealed the use of a pelvic restraint was identified as a problem deficit related to prevention of falls and for safety. Diagnosis of Anoxic Brain Injury/Vascular Dementia. The goal established stated the resident would suffer no harm or injury related to restraint use over the next 30 days. The target date was identified to be 08/22/19. Interventions planned included applying the restraint as ordered: therapy consults as ordered: notify physician of changes in status: release and reposition every two (2) hours and as needed with range of motion (ROM) to extremities for 10 minutes: circulation checks every 30 minutes: two (2) staff assistance with all transfers; monthly restraint review with attempt at least restrictive device; document any changes; and obtain consent from correspondent annually and with changes. The care plan did not address the use of a pelvic restraint when in bed or address the use of a geri-chair. An interview was conducted with the Registered Nurse (RN)/ MDS Coordinator, on 06/13/19 at 2:18 PM. The MDS Coordinator stated she had been in the position for approximately two (2) weeks, and had not conducted the resident's assessments. The MDS Coordinator acknowledged being aware of the restraint concerns in the facility. And when she first started working in the facility had created a spreadsheet and initiated evaluations of residents with restraints. A request was made for documentation regarding restraint assessment that demonstrated on-going evaluation was occurring for the need for arestraint and alternatives attempted as planned in the care plan, to include monthly assessments. The MDS Coordinator was unable to produce the monthly	F 604			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 604	Continued From page 30 restraint assessment documentation, or provide evidence of restraint reduction attempts. An interview was conducted, on 06/13/19 at 12:37 PM, with the attending Physician for Resident #36. The Physician stated the resident was restrained with a pelvic restraint when in bed. According to the Physician the order was given due to staff reporting the resident had rolled from the bed and hit his eyebrow. The Physician stated in addition to the pelvic restraint when in bed, a bedside landing mat and bed lowered were used for safety. The Physician confirmed the only reason a physical restraint order was given was because the resident had rolled out of the bed. An interview was conducted, on 06/13/19 at 1:52 PM, with CNA #8, who was assigned to provide care for Resident #36. CNA #8 stated she frequently worked the night shift, and the resident was already in bed when her shift started. CNA #8 stated the resident always had a pelvic restraint on when in bed. CNA #8 stated the floor mat was always on the floor, and the bed was set at medium height. CNA #8 stated she had found at times the restraint was not straight on the resident because he moves around a lot in bed, and when she finds this she always repositioned it. CNA #8 stated she does assist the resident out of the bed in the mornings by removing the pelvic restraint and transferring the resident to a geri-chair. According to CNA #8, she has been instructed that the geri-chair should always be reclined, allowing the resident to straighten his legs out. An interview was conducted, on 06/12/19 at 10:55	F 604			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 604	Continued From page 31 AM, with the RN Nurse Administrator. The RN stated when she first began employment at the facility, in February 2019, she had noticed the high number of geri-chairs and restraints being utilized by the facility. The RN stated she had initiated bringing the concern to the Quality Assurance and Performance Improvement (QAPI) Committee in an attempt toward reduction. In addition, the RN stated she had contacted the Occupational Therapy (OT) Department to have them come evaluate the high number of geri-chairs to determine if there were more appropriate chairs that could be used by the residents. The RN Nurse Administrator stated she realized there were people in restraints who needed to be evaluated to determine the need for continued use. The facility utilized a pelvic restraint for Resident #36 in response to a fall from bed. There was no evidence the facility identified the medical symptom being treated, assessed for use of least restrictive measures, provided on-going monitoring of the resident for continued use of a physical restraint device, and developed interventions for reducing or eliminating the use of a physical restraint.	F 604			
F 636 SS=D	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.	F 636		8/7/19	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 636	Continued From page 32 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. (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)	F 636			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 636	Continued From page 33 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 observation, staff interview, and record review, the facility failed to conduct an accurate comprehensive assessment of each resident's status, one (1) of 32 sampled residents, Resident #12. Resident #12 was observed to utilize physical restraints. Interview with staff and record review revealed the resident was utilizing a physical restraint at the time of the most recent annual Resident Assessment Instrument (RAI), comprehensive assessment, dated 03/25/19. The Minimum Data Set (MDS) assessment failed to identify the use of physical restraints for the resident, and did not trigger on the Care Area Assessment summary (CAAs). As a result, information regarding restraint use was not gathered and evaluated prior to the development of the comprehensive care plan. Findings include: Resident #12 was observed, on 06/10/19 at 12:25 PM and on 06/11/19 at 12:32 PM, seated in a wheelchair in the dining room during each observation, waiting for the noon meal to be	F 636	a. What corrective action(s) will be accomplished for those resident(s) found to have been affected by the deficient practice? Resident # 12 was assessed by the facility Director of Nursing (DON) on June 13, 2019 to verify the need and safety risks associated with the use of restraints. The DON met with the Interdisciplinary team (IDT) and facility physician on June 13, 2019 to discuss the need for restraints for resident # 12. The Restraint Reduction and Fall Risk assessment was updated on resident #12 by the Minimum Data Set, (MDS) nurse on 6/13/19. The physician gave orders to discontinue the restraints on resident #12. Resident #12 care plan was updated and the representative was notified upon completion of the restraint reduction and Fall Risk assessment and of new orders by the MDS nurse on June 13, 2019. The physician discontinued the restraint order on resident #12 on June 13, 2019. On June 14, 2019 the new MDS Nurse completed a Quarterly Assessment for		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 636	Continued From page 34 served. On both days the resident was observed to have a pelvic restraint in place that was tied in the back to each of the anti-tip bars of the wheelchair. During the 06/11/19 12:32 PM observation, the resident was observed to grab the mesh part of the pelvic restraint and pull it away from his body. Observation of Resident #12, on 06/12/19 at 10:30 AM, revealed the resident was in the dining room for a group activity. The resident was again noted to be seated in a wheelchair with a pelvic restraint in place. Review of the medical record revealed Resident #12 was assessed on an Annual Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 03/25/19, to have a Brief Interview for Mental Status (BIMS) score of 14, indicating independent cognitive skills for daily decision making. The resident was assessed to be independent, with no staff assistance or oversight, in transfers and locomotion on/off the unit. The assessment identified that there were no physical restraints used for Resident #12 during the review period. Review of the Physician's Orders, for Resident #12, revealed the resident had a restraint order, dated 03/11/19, that specified: Restraint order: Pelvic restraint while in geri-chair (geriatric-chair) for safety/positioning x 30 days. Release/reposition every two (2) hours with circulation checks every 30 minutes. Diagnosis: Lewy Body Dementia (Protein deposits, called Lewy bodies, develop in nerve cells in the brain regions involved in thinking, memory, and movement/motor control). The restraint order was given 14 days before the MDS assessment	F 636	Resident #12. b. How will the facility identified other residents having the potential to be affected by the same deficient practice, and what corrective actions will be taken? On June 13, 2019 the MDS nurse and DON reviewed the Resident's Roster Matrix and identified five (5) other residents that have the potential to be affected by the same deficient practice. The MDS nurse reviewed the MDS assessment schedule on 6/13/19 and did not identify that comprehensive assessments were due for those five residents with restraints. c. What measures will be put into place or what systemic changes will be put in place to ensure that the deficient practice does not recur? On July 31, 2019, the new facility MDS nurse in-serviced/educated the facility IDT on MDS assessments policy and procedures. The Jacquith Nursing Home, Nurse Administrator audited eight medical records on 6/18/19 and 6/19/19 to ensure accurate Comprehensive Assessments were available according to the assessment schedule. No other deficient practices of restraints not being identified on the MDS were noted. The MDS nurse audited the MDS global access on July 30, 2019 and found no missing comprehensive assessments. d. How will the corrective action be monitored to ensure the deficient		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 636	Continued From page 35 ARD date of 03/25/19. Review of the medical record revealed Resident #12 received Physical Therapy (PT) services from 01/29/19 through 03/20/19. The Physical Therapy documentation entitled, "Physical Therapy Plan of Care", revealed the resident's long-term goals were established with a goal date of 03/25/19. Review of Nursing Notes, documented on 03/20/19, revealed Physical Therapist (PT) #7 brought Resident #12 back to the unit, and stated she was discharging the resident from therapy services due to the resident fighting. An interview conducted, on 06/13/19 at 8:30 AM, with PT #7, who provided therapy services for Resident #12, confirmed Resident #12 was discontinued from therapy services, on 03/20/19, when the resident exhibited aggressive behavioral symptoms. PT #7 stated prior to therapy services the resident sat in a geri-chair with a pelvic restraint being applied, however, the resident was ambulatory with an unsteady gait. PT #7 stated the goal was to get the resident out of the restraint and ambulating independently. Ultimately the goal was met, however, due to the resident's behaviors the staff had to continue to apply the pelvic restraint. The resident was changed from a geri-chair to a wheelchair with the pelvic restraint applied. PT #7 confirmed the nursing note regarding the resident exhibiting aggressive behaviors, on 03/20/19, after being returned to the unit where he resided. According to PT #7 the pelvic restraint was applied to the resident as he sat in a wheelchair. The nursing note, on 03/20/19, did not document the pelvic restraint application.	F 636	proactice will not recur? What quality assurance program will be put in place? The MDS nurse will compare the facility census and MDS calendar to confirm that each resident has been included on the MDS calendar. During the weekly IDT meeting, the MDS nurse will ensure that each resident's individual needs are being reviewed for the scheduled MDS assessment. The facility DON will review two (2) MDS assessments prior to submission to ensure accurate and timely completion, weekly for 2 weeks then monthly for 3 months. Audit results will be reviewed by the Quality Assurance Performance Improvement (QAPI) Committee every other month and 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 actions to be implemented. The corrective action will be completed on 8/7/19.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 636	Continued From page 36 An interview was conducted with the Registered Nurse (RN)/MDS Coordinator, on 06/13/19 at 2:18 PM. The MDS Coordinator stated that she had recently started working in this position. The MDS Coordinator stated that she had identified the numerous amount of physical restraints being used by residents in the facility, she had initiated evaluations of residents with restraints. When questioned regarding the annual comprehensive assessment, dated 03/25/19, not identifying physical restraint use for Resident #12, the MDS Coordinator stated she could not explain why the previous MDS Coordinator had not properly assessed the resident for restraint use. An interview was conducted, on 06/12/19 at 10:55 AM, with the RN Nurse Administrator. According to the Nurse Administrator one of the first concerns she had upon beginning employment at the facility, in February 2019, was the large number of geri-chairs and physical restraints being utilized by residents. The Nurse Administrator stated she recognized the need for evaluation and potential reduction of the use of these devices. The Nurse Administrator stated she realized there were residents in restraints who needed to be evaluated to determine if the least restrictive devices were being used or if the devices could be eliminated. Interview and record review demonstrated Resident #12 utilized a pelvic restraint while up in a wheelchair during the annual MDS assessment, with an ARD of 03/25/19, and the facility failed to identify the restraint use on the comprehensive assessment. As a result, the use of restraints did not trigger on the CAAs and additional assessment was not performed to assist in the	F 636			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 636	Continued From page 37	F 636			
F 656 SS=D	development of an individualized plan of care to address restraint use for the resident. Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the	F 656		8/7/19	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 656	Continued From page 38 community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to develop and implement a Comprehensive Care Plan to address desired outcomes to meet each residents' needs for three (3) of 32 sampled residents, Resident #3, Resident #12 and Resident #36. Resident #3 was assessed to have a deficit in the ability to self-initiate participation in an activities program and was determined to require a care plan to direct staff in assisting the resident with activity participation. The facility failed to implement the developed care plan interventions, and the resident was observed to remain on the unit where she resided without staff assistance to attend and participate in group activities occurring in the facility. Resident #12 and Resident #36 were identified to utilize physical restraints. The facility failed to develop and implement an individualized comprehensive care plan for each resident related to the use of physical restraints. Findings include: Resident #3 Record review revealed Resident #3 was	F 656	1. How the corrective action(s) will be accomplished for those resident(s) found to have been affected by the deficient practice; Resident #3 was hospitalized on 6/17/19 and expired in the hospital on 6/21/19. Care plan of resident #12 was reviewed and updated to reflect the individualized needs and the discontinued restraint by the facility Minimum Data Set (MDS) nurse on 6/13/19. Care plan of resident #36 was reviewed and updated to reflect the individualized needs and the discontinued restraint by a facility licensed nurse on 7/31/19. 2. Identification of other residents having the potential to be affected was accomplished by the same deficient practice; The facility has determined by the census that 46 residents have the potential to be affected by the deficient practice. On 7/30/19 and 8/1/19, corrective actions were taken and the MDS nurse updated care plans to meet each individualized needs on four residents. a. What measures were put in place or what systemic changes will you put into place to make sure that the deficient practice does not reoccur?		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 656	Continued From page 39 admitted by the facility, on 09/08/10. Resident #3's diagnoses included Congestive Heart Failure (CHF), Alzheimer's Disease and Anxiety. Review of the Annual Minimum Data Set (MDS) for Resident #3 documented the resident was unable to answer interview questions. Staff assessed that Resident #3 was severely cognitively impaired. Review of Resident #3's preferences for customary routine and activities indicated the resident preferred to receive snacks between meals; family involvement; listening to music; participating in favorite activities and spending time away from the nursing home. The resident required extensive assistance of one (1) person for bed mobility and transfer, and was totally dependent on staff for locomotion on and off the unit. Review of the Care Area Assessment (CAA) Summary for Resident #3 indicated that the activities would be addressed in the care plan. Review of the (Care Area Triggers) CAT Worksheet for Activities Problem Area for Resident #3, dated 12/17/18, revealed staff assessment of Activities. Health Issues Affecting Activity Participation included: use of psychoactive medications, functional mobility problems, physical disability, cognitive deficits and chronic health conditions such as incontinence or pain. Notes in Care Plan Consideration- Activities CAA Triggered. Will Care Plan. Review of Care Plan for Resident #3, that was updated on 03/17/19, revealed there was no care plan developed for this resident activity. An interview with Mental Health Recreation	F 656	All interdisciplinary care plan team members responsible for writing care plans were re-educated on the facility's policy and procedure for developing Comprehensive Care Plans by the new Minimum Data Set nurse on 7/31/19. The nursing staff was in-serviced/educated by the new Minimum Data Set nurse on updating care plans with significant changes and new orders on 8/01/19. b. How will the corrective action be monitored to ensure the deficient practice will not reoccur? What quality assurance program will be put in place? Care plans in accordance with the care plan review schedule will be reviewed weekly by the new MDS nurse and facility Director of Nurses (DON). All care plans will be updated as indicated. The Director of Nursing Services (DNS), or Registered nursing staff, will complete random weekly audits of (5) five care plans for four (4) consecutive weeks then monthly. Random audits will be completed to ensure that comprehensive care plans are developed and individualized for residents. Findings of this audit will be discussed with the Nursing Home Administrator, (NHA.) The NHA will report findings, the progress and effectiveness of the corrected actions to the Quality Assurance Performance Improvement (QAPI) committee meeting each month. Should systemic changes not be effective, QAPI committee will investigate and determine further action(s) to be implemented.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 656	Continued From page 40 Therapist (MHRT) #4, on 06/12/19 at 10:35 AM, revealed there were two (2) Recreation Therapists and MHRT #4 is responsible for the males in building 31. The resident's activity care plans were developed by the recreation team and were individualized for each resident. For example, a resident with cognitive issues was provided sensory stimulation. For residents with outbursts they note on the care plan how to redirect the resident for them to remain in the group. Interview with Mental Health Recreational Therapist (MHRT) #5, on 06/12/19 at 11:21 AM, revealed that sometimes the residents from the Women's side are wheeled into the dining room for music activities/ chapel. MHRT #5 was unable to discuss the residents' care plans. Immediately after the interview with the MHRT #5, the Supervisor for Campus Activities entered the Visitor Room and stated that she would talk with the residents and ensure that their interests were incorporated into the activities that were planned. The Supervisor for Campus Activities stated that the CNA's should have some interaction with the residents. Resident #12 Resident #12 was observed throughout the survey dates (6/10 to 13/19) to be up in a wheelchair with a pelvic restraint in place which prevented the resident from standing. Observations, on 06/10/19 at 12:25 PM, on 06/11/19 at 12:32 PM, and on 06/12/19 at 10:30 AM, revealed the resident was seated in a wheelchair, positioned at a table in the dining room. The resident was observed each time to	F 656	The corrective action will be completed on August 7, 2019.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 656	Continued From page 41 have a pelvic restraint in place that was tied in the back to each of the anti-tip bars of the wheelchair. Resident #12 was assessed on the most recent Annual Minimum Data Set (MDS) assessment, dated 03/25/19, to be independent in cognitive skills for daily decision making and independent with bed mobility, transfers, and locomotion. Physical restraint use was not indicated for the resident on the MDS assessment. There was no evidence the facility evaluated the restraint use to determine if on-going use of the device was necessary/least restrictive or to assist in the development and implementation of care plan interventions to prevent and address any risks related to restraint use. Review of the Physician's Orders for Resident #12 revealed an order for a pelvic restraint for safety and positioning was in place on 03/11/19, 14 days before the 03/25/19 Assessment Reference Date (ARD) of the Annual MDS assessment. Continued review of the physician's orders revealed the order for a pelvic restraint was an on-going monthly order, with the most recent order dated 06/10/19. Review of the resident's Care Plan revealed restraint use was identified as a problem deficit on 07/11/17, with a quarterly review being completed on 03/10/19. The problem statement indicated the resident used a pelvic restraint while in the geri-chair for safety, and the resident removed the restraint and stood up without assistance, frequently. However, a notation was made on the Care Plan that specified the Care Plan addressing restraint use had been discontinued on 03/20/19. A second notation was made on the Care Plan, on 04/18/19, that also	F 656			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 656	Continued From page 42 stated the restraint Care Plan was discontinued. Although Resident #12 was observed to be physically restrained with a pelvic restraint throughout the survey dates of 6/10 to 6/13/19, there was no Care Plan developed to direct staff in the provision of care and services related to the restraint use. Continued review of the Care Plan for Resident #12 revealed a risk for falls was identified on 05/15/17, with a review date of 03/10/19. The fall risk was identified as being related to Dementia, unsteady gait, side rails, geri-chair, pelvic restraint, and Parkinson's. The goal established to address the resident's risk for falls stated, "Resident will be free of falls." Although the use of a pelvic restraint was assessed as a potential contributor to the resident's fall risk, there were no interventions planned to direct staff regarding the use of the device to decrease the risk for falls. There was no mention of the use of a pelvic restraint in the planned approaches/interventions. An interview was conducted with the Registered Nurse (RN)/Minimum Data Set (MDS) Coordinator, on 06/13/19 at 2:18 PM. The MDS Coordinator agreed the Care Plans to address restraint use for residents were not individualized, or based on on-going assessment of each resident's needs related to the use of a restraint. The facility failed to develop a Care Plan for Resident #12 that demonstrated justification for the use of a restraint, the type of restraint necessary, frequency of duration the restraint should be applied, or interventions to address potential or actual complications from restraint use. Resident #36	F 656			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019	
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN				STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 656	Continued From page 43 Resident #36 was assessed on a Quarterly Minimum Data Set (MDS) assessment, dated 05/10/19, to have utilized a trunk restraint daily, during the review period. The quarterly assessment identified the resident to be totally dependent on two (2) staff persons with bed mobility and transfers. Resident #36 did not walk during the review period, and was dependent on one staff person for locomotion on and off the unit, utilizing a geri-chair. Review of the Care Plan for Resident #36 revealed, on 08/28/18, pelvic restraint use was identified as a problem deficit related to prevention of falls and for safety due to a diagnosis of Anoxic Brain Injury/Vascular Dementia. A goal was established for the resident to suffer no harm or injury related to restraint use, over the next 30 days. The restraint Care Plan target date was identified as 08/22/19. Interventions included applying the restraint as ordered, consults as ordered, notify physician of changes in status, release and reposition every two (2) hours and as needed, with range of motion (ROM) to extremities for 10 minutes. Circulation checks every 30 minutes, two (2) staff persons with all transfers, and monthly restraint review with attempt at least restrictive device. The Care Plan addressing restraints contained no evidence that interventions were developed or implemented to prevent and address any risks the use of a pelvic restraint while in bed could pose for Resident #36. An interview was conducted with the Registered Nurse (RN)/MDS Coordinator, on 06/13/19 at 2:18 PM. The MDS Coordinator acknowledged recognizing the Care Plan regarding restraints did			F 656			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 656	Continued From page 44 not adequately address the development and implementation of interventions to prevent and address any risks associated with restraint use. A request was made for documentation regarding restraint assessment that demonstrated on-going evaluation was occurring for the need for a restraint and alternatives attempted as planned in the care plan. The MDS Coordinator was unable to produce the monthly restraint assessment documentation.	F 656			
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, and review of the Lippincott Manual of Procedures (Seventh Edition), the facility failed to follow professional standards of practice to prevent the possible spread of infection and/or cross contamination as evidenced by failure to ensure proper hand hygiene during the medication administration observation. This concern was identified for two (2) of four (4) residents observed during medication observation pass, Residents #34 and #46. Findings include: During the medication administration observations on 06/12/19 at 8:40 AM and 8:45 AM, for Residents #34 and #46 Licensed Practical Nurse (LPN) #1 was observed to empty	F 658	a. How the corrective action(s) will be accomplished for those resident(s) found to have been affected by the deficient practice? Resident #34 and #46 were assessed by the facility Director of Nursing (DON) on June 12, 2019 for negative outcomes related to Licensed Practical Nurse (LPN) #1 not washing hands during medication administration and potential cross contamination. No negative outcomes were noted on the assessment. Also on Jun 12, 2019 LPN#1 was immediately in-serviced by the Jaquith Nursing Home (JNH) Nurse Administrator and the facility DON on proper hand hygiene during medication administration. LPN #1 was checked off by the facility DON on proper	8/6/19	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 658	Continued From page 45 the residents' medications into the palm of her bare hand and then place the medications into a medication cup with her bare finger tips. LPN #1 failed to wash or sanitize her hands before setting up and administering the residents medications and between residents. An interview, on 06/11/19 at 3:00 PM, with the Director of Nursing Services (DON)/Registered Nurse (RN) #1, revealed the facility referenced the Lippincott Manual of Procedures (Seventh Edition) for procedural steps for Standards of Care for the following: Medication: Oral, PO (by mouth) meds pages 564-566. Review of the pages for this procedure were as followed: Gather the prescribed medication and appropriate equipment. Perform hand hygiene. Give the patient his/her medication and an appropriate vehicle or liquid, as needed. On 06/12/19 at 11:00 AM, the Director of Nursing Services (DON) observed LPN #1 demonstrate how she administered the medications to Resident #34. LPN #1 was observed to touch the medication with her bare fingertips and bare hands. At this time the DON stopped LPN #1, and explained that she was not to touch medications with her bare fingers. LPN #1 was asked if she knew what she had done wrong, and she stated, "I cross contaminated the medication during medication administration." An interview with the Nurse Staffing Educator, on 06/12/19 at 12:10 PM, regarding these observations of LPN #1 dumping the medications she was preparing to administer into the palm of her bare hand, and to obtain the medication from the medication bottle with her bare fingertip. The Nurse Educator stated, "The nurse should not be	F 658	handwashing. On July 3, 2019 LPN #1 attended medication administration remediation classes conducted by Mississippi State Hospital (MSH) Nurse Educator. b. How the facility identified other residents having the potential to be affected by the same deficient practice? The Director of Nurses and RN staff nurse reviewed the medication administration records on 7/30/19 and determined that 46 residents receiving medications have the potential to be affected by this deficient practice. c. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? On July 3, 2019 LPN #1 attended medication administration remediation classes conducted by Mississippi State Hospital (MSH) Nurse Educator. From July 31 to August 1, 2019 facility licensed nursing staff were in-serviced on the MSH, Infection Control Hand Hygiene Policy and Procedure (P & P). This in-service also included the MSH Infection Control Preventionist Nurses observing the licensed nurse staff perform hand hygiene during medication administration. The observation findings were reviewed with the facility licensed nursing staff and corrective action feedback was provided as needed. From July 31 to August 2, 2019 the facility licensed nurse staff viewed the Center for Disease Control (CDC) web site's, Clean Hands Count campaign video. d. How will the corrective action be		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 658	Continued From page 46 placing the medications into the palm of her bare hand, or taking the medications from the medication bottle with her bare fingertips to place in the medication cup, that is an Infection Control issue." Review with the Staff Nurse Educator of LPN #1's personnel files for staff training titled, "Administration of Medications and Infection Control/ Hand Hygiene" revealed LPN #1 had been in-serviced with a Power Point on Self Handling of Parenteral Medications, Infection Control, which she was tested and checked off as completed this training on 05/14/18. Review of the Power Point page for Self -Handling of Parenteral Medications revealed the statement "Proper hand hygiene should be performed before handling medications." Review of LPN #1's personnel record revealed she was hired on 05/14/18, and had four (4) days of orientation from 05/14 to 05/18/18 which she received the following training: Power Point of Safe Handling of Parenteral Medications, Medication Administration, Infection Prevention, and Hand washing.	F 658	monitored to ensure the deficient practice will not reoccur? What quality assurance program will be put in place? The MSH Infection Control Preventionist Nurse will complete validation checklists of facility licensed nursing staff performing hand hygiene during medication administration in accord with facility P & P. From July 31, 2019 the preventionist nurse will conduct random, weekly monitoring of 2 licensed nurses on each shift for two (2) weeks. On August 15, 2019 the preventionist nurse will conduct same monitoring monthly. The facility DON will audit the validation weekly and monthly checklists. The DON will discuss audit findings with the facility Nursing Home Administrator (NHA) and the JNH Medical Director. The NHA will report findings, progress and effectiveness of the corrective action to the facility Quality Assurance, Performance Improvement (QAPI) committee every other month. Should systemic changes not be effective, the facility QAPI committee will investigate and determine further corrective action(s). The corrective actions will be completed by August 6, 2019.		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable	F 660		8/6/19	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 660	Continued From page 47 readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined	F 660			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 660	Continued From page 48 to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, record review and review of facility policy, revealed the facility failed to develop discharge planning for Resident #45, who expressed an interest in moving into an apartment in another state, This concern was identified for one (1) of 32 residents reviewed. Findings include: Review of the facility's document titled,	F 660	a. What corrective actions will be accomplished for those residents found to be affected by the deficient practice? On June 17, 2019 the facility social worker provided opportunities for discharge to resident #45 and verified that the resident could understand and documented in the resident's health record. The social worker then implemented discharge planning for resident #45 based on two options the resident desired (1st option,		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 660	Continued From page 49 "Mississippi State Hospital POL J510-51 Whitfield, Mississippi 39193 Discharge Planning", dated September 2017 revealed: Policy. It is the policy of Jaquith Nursing Home to provide each resident with planned and coordinated care to meet his/her individual needs, both within the facility and after discharge. It is the goal of this facility to provide sufficient preparation and orientation to residents to ensure safe and orderly discharge from the facility. A resident's discharge plan will be coordinated using input from the treatment team involved in the resident's care, the resident, and the resident's responsible party. Jaquith Nursing Home provides sufficient preparation and orientation to residents to ensure safe and orderly discharges from the facility. This facility permits each resident to remain in the facility, and only discharges residents for the following reasons: 1. The residents and/or his/her authorized healthcare representative requests discharge. E. The assigned social worker, in concert with the resident, his/her authorized healthcare representative and the interdisciplinary treatment team, will develop a written discharge plan to include: 1. The reason for discharge. 2. The date of discharge. 3. The location to which the resident will be discharged. 4. The availability of community resources identified by the interdisciplinary treatment team which may be required to meet the resident's post-discharge needs. An interview with Resident #45, on 06/11/19 at 8:49 AM, revealed that she wanted to move back home to (Name of Out of State City). Resident #45 did not speak, but wrote her messages on a notepad. When asked whether there would be someone available to assist her with her needs in (Name of Out of State City) Resident #45	F 660	2nd option). The social worker made contacts with facilities in 1st option and the Office of Community Based Services and Division of Medicaid. On June 20, 2019 it was determined that resident #45 did not currently meet requirements and source of income for discharge to 1st option. Also on June 20, 2019 the social worker made contacts with facilities in the 2nd option with the potential to meet resident #45's care needs and the Office of Community Based Services and Medicaid. On August 1, 2019, while waiting for a response from a 2nd option facility, resident #45 asked the social worker to cease exploring options for discharge to a facility in 2nd option and that she no longer wished to discharge. The resident's discharge plan was updated to reflect these changes. b. How will you identify other residents having the potential to be affected by the same deficient practice, and what corrective actions will be taken? Any resident who desires to discharge from the facility has the potential to be affected. The facility social worker will interview residents as part of their quarterly MDS assessments and ensure current discharge goals are being accounted for in the discharge plans. In each interview the facility social worker will inquire as to the resident's desire to discharge and of the resident's goals in regard to discharge. The social worker will develop the discharge plan and report to the Jaquith Nursing Home (JNH) social work supervisor monthly.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 660	Continued From page 50 responded that her children were in the that city. Also, Resident #45 indicated that her mother was in Jackson, Mississippi, but she was willing to leave Jackson. Resident #45 indicated that she did not tell the facility Social Worker of her desire to move to (Name of Out of State City). Health record review revealed Resident #45 was admitted by the facility, in January 2014, from the community with diagnoses that included Hemiplegia, Hypertension and Depression. Review of the Annual Minimum Data Set (MDS), dated 09/3/18, for Resident #45 revealed the resident had a Brief Interview for Mental Status Score (BIMS) of 9, indicating moderately impaired cognition. Further review of the Annual MDS indicated the resident had no behavioral symptoms except rejection of assistance with activities of daily living (ADLs). Review of Resident #45's functional status indicated independence for bed mobility, independence for mobility in her room and mobility on and off the unit. Independence eating and toileting. Resident #45 required supervision for dressing, hygiene and bathing. However, Resident #45 required extensive assistance of one (1) person for transfers from bed to wheelchair and wheelchair to bed. Resident #45 had limitations in range of motion in one (1) upper and one (1) lower extremity. Resident #45 was able to control her bladder and bowel. She had sustained no falls and had no complaint of pain. The resident was not on antipsychotic medications or opioid pain medication. There was no discharge planned for Resident #45. Review of the, "Return to Community Referral Care Area Triggers Worksheet", dated 09/3/18,	F 660	c. What measures were put in place or what systemic changes will you put into place to make sure that the deficient practice does not reoccur? On July 16, 2019 the (JNH) Social Work Supervisor conducted an in- service with the facility Social Worker addressing discharge planning. Resident #45 and the need to have a documented discharge plan in the resident s chart was the focus of the in-service. Facility social worker will conduct interviews with residents as part of the quarterly Minimum Data Sets (MDS) assessment. In the assessment the facility social worker will inquire of each resident s desire for discharge. When a resident expresses desire to discharge the social worker will begin discharge planning. In accordance with the resident s desires and goals, the facility social worker will contact family and potential facility options that will meet the resident s care needs. The facility social worker will provide a summary report to the JNH social work supervisor monthly of residents who have expressed the desire to discharge and present the discharge plan(s) to the supervisor for review. The JNH supervisor will ensure that the discharge plans are in compliance and includes desires and goals. d. How will the corrective action be monitored to ensure the deficient practice will not reoccur? What quality assurance program will be put in place?		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 660	Continued From page 51 for Resident #45 indicated other factors to consider regarding the resident's discharge assessment and planning for community support include: Cognitive skills for decision making and cognitive deficits. Functional mobility or balance problems. There was no indication of input from the resident, family or representative. There were no referrals to other disciplines. There was no care plan consideration for discharge for Resident #45. Review of the Quarterly MDS for Resident #45 dated 05/24/19 revealed no active discharge plan. An interview with Resident #45's Physical Therapist (PT), on 06/12/19 at 8:56 AM, revealed that the resident was seen by the therapists three (3) times a week. Resident #45 was new on the PT caseload. The PT stated Resident #45 had improved. The PT stated she was not aware of Resident #45's ability to perform her activities of daily living (ADLs). An interview with Direct Care Supervisor/Certified Nursing Assistant (CNA) #9, on 06/12/19 at 9:14 AM, regarding Resident #45, revealed the resident refuses showers. The CNA Direct Care Supervisor stated that Resident #45 washes herself up in her bedroom sink. Also, Resident #45 was often assisted after she toileted herself. Review of the, "Interdisciplinary Notes", dated 01/09/19, by the Social Worker (SW) for Resident #45 indicated that the resident was upset and wanted to move into an apartment. The SW indicated that Resident #45 did not have the family support or financial means to move into an apartment. The SW wrote that Resident #45	F 660	On August 1, 2019 the JNH social work supervisor began auditing health records every other week. The JNH social work supervisor will conduct these audits until December 31, 2019. As of January 1, 2020 the supervisor will begin auditing health records monthly. The purpose of the audit is to identify residents who have expressed a desire to discharge from the facility or have expressed a change in discharge desires and goals. The purpose will also review the comprehensive discharge plan of care and social services progress note for discharge planning to ensure changes documented. JNH social work supervisor will report any issues to the facility NHA. The NHA will report the progress and effectiveness of the corrective action to the facility Quality Assurance and Performance Improvement (QAPI) committee.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 660	Continued From page 52 needed some assistance with ADLs. According to the SW's note Resident #45 had a sister who would come to visit the resident. The SW wrote in the same note: "She is angry and keep stating, I want to move." The Social Worker indicated that she would continue to provide supportive counseling to Resident #45. Review of the, "Social Work MDS Quarterly/Bimonthly Assessment Note", for Resident #45, dated 03/04/19, revealed Resident #45 was ambulatory via wheelchair, and could feed and dress herself. Also, she was continent of bladder and bowel. Resident #45 was oriented to person, place and time. Her speech was difficult to understand, so she had trouble making her needs known effectively. Resident #45 had not been hospitalized this quarter. "There is no potential for discharge because "named" resident has no primary caregiver to provide care." The SW wrote that Resident #45 expressed an interest in going to (Out of State City) and living there. The SW determined after she consulted with Resident #45's family in Mississippi that there was no family to care for her in that city. Review of the, "Social Work MDS Quarterly/Bimonthly Assessment Note", for Resident #45, dated 05/21/19 indicated that there was no potential for discharge because the resident had no primary caregiver to provide care. Because the facility's Social Worker (SW) was not in the facility, an interview was conducted with the Mississippi State Home Nursing Home Social Work Supervisor, on 06/13/19 at 11:03 AM. The Social Work Supervisor stated that though the SW for this building had talked to her about Resident #45, she had not had any direct contact	F 660			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 660	Continued From page 53 with the resident. The SW Supervisor stated she had not discussed the resident's desire to move, or options for moving with the facility SW. No details about Resident #45 were discussed by the facility SW with the SW Supervisor. The Nursing Home SW Supervisor stated that she will explore the options with the SW for this facility when she returns regarding Resident #45's desire to move out of state city. The Supervisor stated that there may be community resources and Medicaid resources that Resident #45 could benefit from that would allow her to make a transition as desired. The facility SW failed to document research to support Resident #45's move or find a viable option because the resident required assistance with ADLs and had no family support in Chicago. Review of the SW "Assessment" and "Interdisciplinary Notes" revealed no evidence of any research into the opportunities for Resident #45 in Chicago before denying the discharge.	F 660			
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by:	F 679		8/6/19	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 679	Continued From page 54 Based on observation, staff interview, record review, and facility policy review, the facility failed to provide activities that met the needs and interests for nine (9) residents from a sample of 32 residents, and on one (1) of two (2) units in the facility. This deficient practice had the potential to cause a decline in the mental and physical well-being of these cognitively impaired female residents: Resident #3, Resident #4, Resident #9, Resident #19, Resident #21, Resident #24, Resident #26, Resident #33, and Resident #42. Findings include: Review of the "Mississippi State Hospital Pol 260-01 Whitfield, MS 39193", "Mississippi State Hospital July 2017-Non-Medical on/off Campus Activities" included: Purpose and Applicability. This policy provides guidelines and procedures for determining the number of patients/residents to participate in on/off non-medical campus activities, the number of staff to accompany patients/residents and the responsibility of staff related to on/off non-medical campus activities. This policy applies to all Inpatient Services (IPS) including Jaquith Nursing Home (JNH) staff participating in any on/off non-medical campus activity. Policy. JNH "Jaquith Nursing Home" will provide adequate staff for all patients/residents while attending non-medical on/off campus activities. An observation, on 06/11/19 at 9:03 AM, revealed nine (9) residents in Women's Day room seated in geri-chairs lined up against the walls. Resident #18 was heard repeatedly moaning loudly. The television (TV) was tuned to a "cooking" show playing softly at the far end of the room with one (1) resident seated directly in front of the	F 679	a. What corrective actions will be accomplished for those residents found to be affected by the deficient practice? The Monthly Calendar was updated for the deficient month on 6/14/19. Structured activities are updated and current on the Activity Calendar and conducted according to the calendar by Activities Staff 7/30/19, Residents #3, #4, #9, #19, #21, #24, #26, #33, and #42 were assessed by the Jaquith Nursing Home (JNH) Activities Staff using the Therapeutic Recreation Assessment (JNH-98) to reassess the residents activity preferences to ensure that the needs and interest of the residents are being met. Non-verbal residents have been assessed based on their past lifestyles from previous medical records as documented from interactions with residents and their family members. Also, on 7/30/19, Activities Staff and CNA Staff were in-serviced by the JNH Activity Supervisor on the facility's activity policy 260-01. CNA Staff were also in-serviced on the engagement of staff while residents are involved in structured activities and on the engagement of staff to those residents that choose not to attend using the suggested activity box in the dayroom. The suggested activity box contains items and objects that are compiled taking into account all of the residents' listed interests in activities and hobbies that have been documented in their respective medical records. Beginning, 6/24/19, for accountability purposes, attendance and participation is		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 679	Continued From page 55 television (TV). One (1) Certified Nursing Assistant (CNA) was observed in the Women's Day room at a writing desk not interacting with the residents. There was no scheduled activity observed in the Women's Day room at this time. The residents were sitting quietly except for Resident #18. The following residents were observed in the Day Room at this time: Resident #9 was up in a Geri-chair with a waist restraint, and a red pillow behind her neck. Resident #13 was wearing blue sweats, up in Geri-chair leaning forward. Resident #14 was up and ambulatory. Resident #18 was seated with waist restraint. Resident #19 was seated in a Geri-chair. Resident #24 was seated in a Geri-chair. Resident #30 was ambulatory in the room, and was alert and oriented. Resident #33 was up in a Geri-chair had continuous tube feeding via a feeding pump. Resident #42 was moving about the room in a Geri-chair, with her legs over the armrest, talking/babbling to self. An observation on 06/11/19 at 9:21 AM, revealed the activity calendar for May was posted in the Women's Day room. Certified Nursing Assistant (CNA) #10 stated at this time the calendar had not been updated and there should be a June calendar posted. On 06/12/19 at 1:50 PM, nine (9) residents were observed in the Women's Day Room. One (1) resident was seated in front of the TV intently watching the program. CNA #13 was present in the Women's Day Room. CNA #13 stated that she was "pulled" from another nursing home on the hospital campus to help in this building. CNA #13 was seated at the writing desk making notes in a notebook. There was no interaction between CNA #13 and the residents seated in the	F 679	being documented and maintained in the Mental Health Recreation Therapist (MHRT) office. Activity Staff was in-serviced on 8/2/19 on the regulations Ftag 679 presented on YouTube. All resident documentation has been reviewed and updated according to MDS timeline. b. How will you identify other residents having the potential to be affected by the same deficient practice? The JNH Activity Supervisor reviewed the census and determined that any resident could have the potential to be affected but there were none found to be affected. This included reviewing non-verbal residents' medical records to ensure that their desired interests are being engaged appropriately based on their past lifestyles as documented from interactions with residents and their family members. c. What measures were put in place or what systemic changes will you put into place to make sure that the deficient practice does not reoccur? On 6/ 24/19, a new activity staff was assigned to the affected residents. This newly assigned staff member has twelve years of recreational experience on Jaquith Nursing Home. The new activity staff has been educated and updated with the survey findings and the plan of action. The new activity staff and the JNH Activity Supervisor reviewed the activity and participation records for all residents to identify trends of daily activities and of the		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 679	Continued From page 56 Women's Day room. Licensed Practical Nurse (LPN) #12 entered the Women's Day Room, and identified the residents that were present as Resident #3, Resident #4, Resident #9, Resident #19, Resident #21, Resident #24, Resident #26, Resident #33, Resident #42. Observation of the Women's Day Room, on 06/13/19 at 12:00 PM, with the Quality Assurance (QA) Registered Nurse (RN) revealed 12 residents in the day room. Four (4) staff members were also observed in the day room. The staff were talking to each other and not engaging the residents. The QA RN confirmed the staff were not interacting or engaged with the female residents in the day room. An observation on 06/13/19 at 3:47 PM, revealed a cake and beverage social activity for residents was occurring in the dining room. There were 10 to 12 male residents observed in the activity who had been served cake and a beverage. There were no female residents observed participating in the event. An interview was conducted, on 06/13/19 at 3:50 PM, with a Registered Nurse (RN) #3/Floor Nurse. RN #3 was asked why there were no female residents participating in the social activity. RN #3 responded she wasn't sure, but they might be getting dressed. The RN approached a Certified Nursing Assistant (CNA) and both staff persons walked out of the dining room and down the hallway toward the unit where the female residents resided. Almost immediately staff were noted to start pushing female residents in geri-chairs down the hallway and into the dining room. Other female residents were observed to be ambulating with staff beside	F 679	recreational monthly scheduled activities. Also on 6/24/19, the facility activity staff began monitoring the daily scheduled activities. The facility activity staff will document on the Activity Attendance Sheet daily participation of the residents' and maintain these sheets in the activity staff office on the unit. Additionally, facility activity staff will evaluate with regularity the engagement of non-verbal residents to determine if activities should be adjusted to take into account any changes that should be made to increase stimulation, as much as possible, for these residents. These reports will be provided to the JNH Activities Supervisor on a monthly basis. Beginning 7/ 1/19, the JNH Activities Supervisor will review the monthly activity schedules weekly to ensure that it's updated as needed and being followed by the facility activity staff. The results of the weekly reviews will be recorded on the Therapeutic Recreation Services Department Group Facilitation Monitor Form. This form will be maintained by the JNH Activity Supervisor and kept in her office. At the same time of this review, the JNH Activities Supervisor will check for any adjustments that have been made in the attempts to provide meaningful activities to non-verbal residents. Also on 7/1/19, the JNH Activity Supervisor began reviewing residents charts monthly for resident's Assessments, Care Planning and Progress Notes on the Therapeutic Recreation Standard of Care Form. This		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 679	Continued From page 57 them as they entered the dining room. Staff were observed to start serving the women cake and beverages of choice. By this time most of the male residents had finished their cake and beverages. The female residents who were invited and assisted to the social function included: Resident #3, Resident #4, Resident #9, Resident #18, Resident #19, Resident #21, Resident #24, Resident #42, and five (5) unsampled female residents. Further observation in the Dining Room, on 06/13/19 at 4:05 PM, revealed all the female residents, with the exception of Resident #18, had been served cake and a beverage. Resident #18 was observed to be seated at a table with her head down on the table. Continued observation revealed the staff in the dining room did not offer Resident #18 any cake or a beverage. Resident #18 overheard the surveyor ask another resident if she was enjoying the cake and loudly announced, "I want cake. I didn't get any cake. I want cake and ice cream," while continuing to lay her head on the table. Staff in the dining room after hearing the resident's request went to the service kitchen and obtained a piece of cake and a beverage for the resident. Resident #18 was observed to eat the cake served and request a second piece of cake. Staff did obtain and serve the resident a second piece of cake. A review of the Minimum Data Set (MDS)s and Care Plans for cognitive status, activity preferences and activities for the nine (9) residents observed in the Women's Day Room, on 06/12/19 at 1:50 PM, revealed the following: Resident #3	F 679	standard of care form will be maintained in the JNH Activity Supervisor's office. On 7/30/19, an activity box was placed in each dayroom (male and female) that contains activity materials and supplies for alternative activities for the residents that choose not to participate in the scheduled activity. The activity box contains material and supplies that are suggested interest and preferences of the residents compiled based on the assessment of the residents' interests and favorite activities. By implementing these practices, it will ensure that all residents will have a care plan for activities as well as ensuring that all residents are provided activities that meets their needs and interest. d. How will the corrective action be monitored to ensure the deficient practice will not reoccur? What quality assurance program will be put in place? The JNH Activity Supervisor will provide a monthly report of her weekly documented monitoring to the Therapeutic Recreation Services (TRS) Director. Any deficiencies noted will be immediately corrected by the JNH Activity Supervisor. The TRS Director will maintain the monthly reports in her office. The TRS Director will provide a monthly written report to the facility Quality Assurance Performance Improvement (QAPI) committee every other month the progress and effectiveness of the corrected actions. Should systemic changes not be effective, QAPI will investigate and determine further actions		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 679	Continued From page 58 Review of the health record indicated that Resident #3 was admitted by the facility, and was readmitted by the facility, on 02/12/18, with diagnoses that included Alzheimer's Disease and Anxiety Disorder. Review of the Annual MDS, dated 12/17/18, for Resident #3 documented the resident with severe cognition impairment. The resident's activity preferences included listening to music, participating in favorite activity, and spending time away from the nursing home. Review of the Care Area Assessment Summary (CAAS) for Resident #3 indicated that activities triggered for inclusion in the care plan. Review of the current Care Plan for Resident #3, updated 03/17/19, revealed no care plan for activities. Resident #4 Review of Resident #4's health record revealed the resident with a readmission date, of 05/06/13, with diagnosis of Cerebral Palsy. Review of the resident's Annual MDS, dated 12/17/18, documented the resident had severely impaired cognition. The resident activity preferences included listening to music, participating in religious activities, and group activities. Activities did not trigger for this resident. Review Resident #4's updated Care Plan, dated 12/18/18, indicated: Problem-Limited to[sic] participation due to physical/mental condition. Goal - Resident will maintain/improve leisure interests by attending/participating in at least one (1) to two (2) activities weekly for 12-20 minutes. Approaches included: bring resident to the activities and have conversations with the resident. Resident #9	F 679	to be implemented. The corrected actions were completed on 8/6/19.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 679	Continued From page 59 Health record review for Resident #9 revealed the resident was readmitted by the facility, on 07/28/15, with diagnoses included Alzheimer's Disease, Dementia, Anxiety and Depression. Review of the resident's Annual MDS, dated 03/11/19, indicated the resident's cognitive status as severely impaired. The resident's activity preferences were listed as listening to music; and participation in religious activities. Review of the Care Area Assessment Summary (CAAS) for Resident #9 indicated that activities would be addressed in the care plan. Review of the "Activity Care Plan" for Resident #9, dated 09/11/18, indicated: Problem: Limited interaction due to mental/physical condition. Goals: Resident will attend at least one (1) scheduled group activity for 30 minutes and one (1) one to one (1:1) session for 15 to 20 minutes weekly to improve/maintain cognitive skills. Groups will include, but are not limited to chapel, socials, music and building events. Approaches included escort the resident to group activities; have patience; and give praise for appropriate and active behavior. Resident #14 Review of the health record for Resident #14 indicated the resident had a readmission date, of 02/02/15, with diagnoses that included Arthritis and Dementia. Review of the resident's Annual MDS, dated 10/08/18, revealed that Resident #14's Brief Interview for Mental Status Score (BIMS) was 15, indicating intact cognition. Resident #14's choices for activity preferences were all assessed as very important. Review of the CAAS indicated that activities did not trigger	F 679			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 679	Continued From page 60 for the care plan for Resident #14. Resident #19 Review of the health record for Resident #19 revealed the resident was readmitted by the facility, on 04/06/17, with diagnoses included Dementia and Schizophrenia. Review of the resident's Annual MDS, dated 12/17/18, documented the resident had severely impaired cognition. The resident's activity preference included listening to music; participating in favorite activities; and spending time away from the nursing home. Review of the CAAS for Resident #19 revealed that activities triggered to be included in the care plan. Review of the activity care plan for Resident #19, dated 01/18/19, indicated: Problem - Loses interest quickly in activities. Short attention span when in group activities. Goal - Resident will attend/participate in three (3) group activities of choice one (1) time (x) a week for 20-30 minutes to improve attention span. Group will include music, chapel, socials, and trivia. Approaches included: invite resident/remind resident of schedule activities and praise resident participation. Resident #21 Review of the health record for Resident #21 revealed the resident was readmitted by facility, on 11/30/15, with diagnoses that included Schizoaffective disorder and Bipolar disorder. Review of the resident's Annual MDS, dated 10/22/18, documented the resident had a BIMS score of eight (8) indicating moderate cognitive impairment. There were no activity preferences	F 679			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 679	Continued From page 61 documented on the resident's MDS. Review of the CAAS for Resident #21 indicated that activities had triggered for inclusion in the care plan. Review of the Care Plan for activities indicated: Problem onset (12/04/17): Maintain present level of functioning and participation activity related to cognitive impairment. Goal and Target Date (7/25/19): Will participate or be invited to participate in all activities, with the assumption of actually participating in at least one (1) activity scheduled activity over the next 90 days. Approaches: 1. Will be informed daily of activity schedule. 2. Will be encouraged to read posted schedules and choose which activity to participate in. 3. Will be encouraged to maintain interaction with peers and will continue to ask them to join in with activities 4. Will be praised for all activity involvement. 5. Staff to assist to activities as needed.6. Recreation Consults as needed. Resident #24 Health record review for Resident #24 documented the resident was readmitted by the facility, on 07/27/17, with diagnoses that included Dementia and Arthritis. Review of the resident's Annual MDS, dated 01/28/19, indicated the resident had severely impaired cognitive status. The resident's activity preferences included group participation; participation religious activities; and favorite activities. Review of the CAAS for Resident #24 indicated that activities triggered for care planning. Review of the activity care plan for Resident #24, dated 01/23/19, revealed: Problem: Resident has limited involvement due to cognitive decline. Goals: Resident will attend/participate in	F 679			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 679	Continued From page 62 one on one (1:1) activity and a social activity for 15-20 minutes two (2) times a week. Groups will consist of chapel, music therapy and sensory stimulation. Approaches included give the day, date, month and year to resident and encourage continued routine of daily activities. Resident #26 Health record review for Resident #26 revealed the resident was admitted by the facility, on 11/12/08, with diagnoses that included Dementia and Schizophrenia. Review of the resident's Annual MDS, dated 04/19/19, indicated that staff assessed Resident #26 with "modified independence" for making daily decisions. Staff assessed Resident #26's activity preferences were documented that she preferred to listen to music. Review of the CAAS for Resident #26 revealed that activities triggered for care plan. However, the facility was unable to provide a copy of the resident's activity care plan prior to survey exit. Resident #33 Health record review for Resident #33 revealed the resident was readmitted by the facility, on 11/09/15, with diagnoses that included Dementia. Review of the resident's Annual MDS, dated 11/12/18, revealed Resident #33's cognitive status was severely impaired. The resident's activity preferences included listening to music; participating in groups; and religious activities. Review of the CAAS for Resident #33 revealed that activities triggered for care planning. The facility was unable to provide a copy of the resident's activity care plan before the end of the	F 679			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019	
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN				STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 679	Continued From page 63 survey. Resident #42 Health record review for Resident #42 revealed the resident was admitted by the facility, on 03/12/19, with diagnoses that included Dementia, Seizure Disorder and Traumatic Brain Injury. Review of the admission MDS, dated 03/12/19, for Resident #42 revealed staff assessment of severely impaired cognitive status. The resident's activity preferences included listening to music; and participating in religious activities. Review of the CAAS for Resident #42 indicated that activities would be care planned. The facility was unable to provide a copy of the resident's activity care plan prior to the end of the survey. An interview with Mental Health Recreation Therapist (MHRT) #4, on 06/12/19 at 10:35 AM, revealed there were two (2) Recreation Therapists and MHRT #4 is responsible for the males in Building 31. Some activities such as Carnival Day are done with both males and females in attendance. The other therapist MHRT #5 does the activities and calendar for the females. The treatment team consists of all disciplines, including the Activity Therapist. The treatment team meets every Thursday and depending on the MDS Schedule. Activities are discussed in the team meeting. The activities are announced over the intercom to the resident's rooms. The Calendar for the month is posted in the male hallway. All calendars are approved by the Mississippi Mental Health Hospital Activities Supervisor. The resident's activity care plans were developed by the recreation team and were individualized for each resident. For example, a resident with cognitive issues was provided			F 679			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019	
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN				STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 679	Continued From page 64 sensory stimulation. For residents with outbursts they note on the care plan how to redirect the resident for them to remain in the group. An interview with MHRT #5 (responsible for the activities on the women's unit), on 06/12/19 at 11:21 AM, revealed that sometimes the residents from the women's side are wheeled into the dining room for music activities and, chapel. Sometimes the residents are invited into the activities like cards even if they don't participate. This weekend they had a party for all of the residents. Snacks were served, the ones that could participated. Bingo was scheduled every other week. Usually nails were done as a group. MHRT #5 stated that she forgot to put the activities calendar on the bulletin board in the Women's Day room. But stated she had put them up on the wall of each resident's room. An interview was conducted with the Activities Supervisor for the campus immediately after the 06/12/19 at 11:21 interview with MHRT #5. The Activities Supervisor stated that she ensured the activities were done at the facility as scheduled on the calendars posted in the facility. The Supervisor stated she would talk with the residents to ensure that activities that interested them were incorporated into the activities offered. The Activities Supervisor stated that some type of interaction should be included with the residents on the female hall. The CNAs should have some interaction with the residents. An interview was conducted with the Administrator, regarding the activity concerns, and the residents in the female day room, on 06/12/19 at 5:07 PM, on the female side. The Administrator stated that he was not aware of the			F 679			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019	
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN				STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 679	Continued From page 65 state of things regarding activities. He stated that he would address it, right away. An interview with the Attending Physician, on 06/13/19 at 12:09 PM, revealed she had a concern for the residents in the Women's Day Room just sitting in the day room. The Physician also stated the residents need music, sermons, etc., to stimulate them. The "demented" and hard of hearing residents should be involved. The Physician also stated a Recreation Therapist comes with music once or twice a month. Some of the residents that stay in their rooms also needed some stimulation.	F 679					
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following	F 880		8/6/19			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019	
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN				STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 880	Continued From page 66 accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.			F 880			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 880	Continued From page 67 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of the facility's policy, revealed one (1) of two (2) nurses observed during the medication administration passes failed to follow accepted infection control practices to prevent the possibility for the spread of infection and/or cross contamination. Licensed Practical Nurse (LPN) #1 handled medication with her bare hand and fingertips, and did not perform hand hygiene between Residents #34 and #46's medication administration. This concern was identified for two (2) of four (4) residents observed during the medication administration passes. Findings include: Review of the facility's Policy and Procedure, dated April 2019 titled, " Hand Hygiene", revealed the following: Policy. It is the policy of Mississippi State Hospital (MSH) that all employees will use proper hand hygiene techniques to prevent the spread of infectious disease. Indications: Personnel should always cleanse/sanitize their hands: A. Before and after work shift, B. Before and between each patient/resident, C. Before performing invasive procedures, D. Before medication preparation. Resident #34 An observation, on 06/12/19 at 8:35 AM, revealed LPN #1 was moving her medication cart down the hall, and stopped in front of Resident #34's room.	F 880	a. How the corrective action(s) will be accomplished for those resident(s) found to have been affected by the deficient practice? Resident #34 and #46 were assessed by the facility Director of Nursing (DON) on June 12, 2019 for negative outcomes related to Licensed Practical Nurse (LPN) #1 not washing hands during medication administration and potential cross contamination. No negative outcomes were noted on the assessment. Also on Jun 12, 2019 LPN#1 was immediately in-serviced by the Jaquith Nursing Home (JNH) Nurse Administrator and the facility DON on proper hand hygiene during medication administration. LPN #1 was checked off by the facility DON on proper handwashing. On July 3, 2019 LPN #1 attended medication administration remediation classes conducted by Mississippi State Hospital (MSH) Nurse Educator. b. How the facility identified other residents having the potential to be affected by the same deficient practice? The Director of Nurses and RN staff nurse reviewed the medication administration records on 7/30/19 and determined that 46 residents receiving medications have the potential to be affected by this deficient practice.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 880	Continued From page 68 LPN #1 did not wash or sanitize her hands prior to preparing the resident's medications. LPN #1 was observed to pour the medications into the palm of her bare hand, and with her bare fingertips placed them into the paper medication cup. The following medications were prepared: Metoprolol 25 milligram (mg), one half (1/2) tablet of 12.5 milligram (mg), Folic Acid 1 mg, Digitek 0.125 mg. (LPN #1 put her two (2) fingers into the medication bottle, and with her two (2) fingers obtained the medication of Digitek and placed it into the medication cup.), Thiamine 100 mg, Namenda 10 mg. After administering the medications to Resident #34 LPN #1 failed to wash or sanitize her hands before moving to the next resident. Resident #46 An observation, on 06/12/19 at 8:45 AM, revealed LPN #1 moved her medication cart to the next resident. LPN #1 did not wash or sanitize her hands after completing the medication administration for Resident #34, or before preparing the medications for Resident #46. While preparing Resident #46's medication LPN #1 was observed to pour the following medications into the palm of her bare hand, and with her bare fingertips placed them into the paper medication cup: Depakote 500 mg three (3) tablets (1500 mg). (LPN #1 put her two (2) fingers into the medication bottle, and with her two fingers obtained the three (3) Depakote 500 mg tablets and placed them into the medication cup), Vitamin C 500 mg, Aspirin 81 mg, Colace 100 mg, Flomax 0.4 mg, Topiramate 100 mg, Aspirin 325 mg., 2 tablets, Zolof 50 mg, Periactin 4 mg. At 9:10 AM, LPN #1 sanitized her hands	F 880	c. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? On July 3, 2019 LPN #1 attended medication administration remediation classes conducted by Mississippi State Hospital (MSH) Nurse Educator. From July 31 to August 1, 2019 facility licensed nursing staff were in-serviced on the MSH, Infection Control Hand Hygiene Policy and Procedure (P & P). This in-service also included the MSH Infection Control Preventionist Nurses observing the licensed nurse staff perform hand hygiene during medication administration. The observation findings were reviewed with the facility licensed nursing staff and corrective action feedback was provided as needed. From July 31 to August 2, 2019 the facility licensed nurse staff viewed the Center for Disease Control (CDC) web site's, Clean Hands Count campaign video. d. How will the corrective action be monitored to ensure the deficient practice will not reoccur? What quality assurance program will be put in place? The MSH Infection Control Preventionist Nurse will complete validation checklists of facility licensed nursing staff performing hand hygiene during medication administration in accord with facility P & P. From July 31, 2019 the preventionist nurse will conduct random, weekly monitoring of 2 licensed nurses on each shift for two (2) weeks. On August 15, 2019 the preventionist nurse will conduct same monitoring monthly. The facility DON will audit the validation weekly and		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2019
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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 880	Continued From page 69 after administering medications to Resident #46, but did not sanitize her hands before administering medications to Residents #34 and #46. On 06/12/19 at 11:00 AM, LPN #1 was asked by the Director of Nursing Services/ RN #1, to demonstrate how she had administered medication to Resident #34. LPN #1 put her two (2) fingers into the medication bottle, and with her two (2) fingers obtained the medication of Digitex 0.125 mg., and placed it into the medication cup. At this time the Director of Nursing Services/ RN #1 stopped her, and explained that she was not to touch medications with her fingers. LPN #1 was asked if she knew what she had done wrong and she stated, "I cross contaminated the medication during medication administration." An interview with LPN #1, on 06/12/19 at 12:30 PM, revealed she realized she had touched these medications with her two (2) fingers to obtain the medication, and also poured the medications into her bare palm to be placed into the medication cup. LPN #1 stated, "Yes, and I cross contaminated the medication", when she was asked if she realized what she had done.	F 880	monthly checklists. The DON will discuss audit findings with the facility Nursing Home Administrator (NHA) and the JNH Medical Director. The NHA will report findings, progress and effectiveness of the corrective action to the facility Quality Assurance, Performance Improvement (QAPI) committee every other month. Should systemic changes not be effective, the facility QAPI committee will investigate and determine further corrective action(s). The corrective actions will be completed by August 6, 2019.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING 31 B. WING _____		(X3) DATE SURVEY COMPLETED 06/11/2019
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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	
K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

08/09/2019

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/11/2019
NAME OF PROVIDER OR SUPPLIER JNH-ADAMS INN			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 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
E 000	Initial Comments * EMERGENCY PREPAREDNESS * Survey conducted on 6/11/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were identified.	E 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

08/09/2019

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