STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A402	A. BUILDING _____ B. WING _____	07/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JNH-JEFFERSON INN	3550 HWY 468 WEST - PO BOX 207 BLDG 33 WHITFIELD, MS 39193

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey from 7/23/19 through 7/26/19. During the survey, the SA determined the facility was not in compliance with the Medicare and Medicaid Requirements of participation. The SA cited deficiences at F623, F625, F657, F693, and F880. The facility was licensed for 89 beds and had a census of 73 at the time of survey.	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable	F 623		9/3/19

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

Electronically Signed | 08/14/2019

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.

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F 623	Continued From page 1 before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with	F 623		

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F 623	Continued From page 2 developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to notify a Resident Representative, in writing, of a transfer to the hospital for one (1) of two (2) residents reviewed for transfers, Resident #69. Findings include:	F 623	A. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? On 07/25/2019, the Jefferson Inn Nursing Home Administrator reviewed Resident#69' s chart and informed the	

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F 623	Continued From page 3 Review of facility policy titled "Hospital or Therapeutic Leave Bed Hold Policy", dated April 2018, revealed: Before transfer of a resident from (the facility name) to a medical/care facility, the facility must notify the resident and, if known, the representative of the resident, of the transfer in writing and in a language and manner they understand. Record review of a Physician's Order revealed Resident #69 was sent to the hospital on 6/28/19, and returned to the facility on 7/1/19. Record review of Resident #69's chart revealed there was no transfer letter/notice provided to Resident #69 or to their Resident Representative at the time of transfer to the hospital. An interview on 07/25/19 at 10:45 AM, with Resident #69's Resident Representative and next of kin, revealed, "My sister (Resident #69's mother), passed away more than a year ago. I'm 70 years old but stepped in and have tried to help with my niece. The Social Worker has been great to call and tell me when she has gone out but I never received a letter from anyone about her going to the hospital. Now, they called me and told me, but I never got a written letter". An interview on 07/25/19 at 11:53 AM, with the Social Worker, revealed she did not send the family a letter stating that Resident #69 went out to the hospital, nor did she notify the Ombudsman. An interview on 07/25/19 at 03:45 PM, with the facility Administrator, revealed, "We basically call the family when a resident leaves the facility for	F 623	Social Workers of the deficiency. Resident#69 's representative was notified via telephone but staff failed to send written notification. On 08/09/2019,Social Worker was instructed to provide the resident 's representative the reason for transfer/discharge in writing by the Administrator. On 08/12/2019, the Social Worker mailed letters to the resident's representative and the State Long-Term Care Ombudsman notifying that Resident #69 had been admitted to the hospital. On 08/12/2019, Resident #69 received a copy of the notification letter. B. How will you identify other residents having the potential to be affected by the same deficient practice, and what corrective actions(s) will be taken? On 07/25/2019, the Administrator and the Social Workers reviewed the census, four of 73 residents had the potential to be affected by the deficient practice. No others were affected. C. What measures will be put into place, or what systemic changes will you make to ensure that the deficient practice does not recur? On 08/01/2019, an In-service was conducted with the facility 's staff that included the Social Workers, Social Services Supervisor and the Director of Nursing(DON) by the Administrator addressing circumstances regarding	

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F 623	Continued From page 4 the hospital. We don't send a letter to anyone. To my knowledge, we don't send a letter to notify the Resident Representative of a bed hold if a resident goes to the hospital".	F 623	required notices to be mailed, notifying the resident, resident's representative and the State Long-Term Care Ombudsman for residents upon transfer and discharge from the facility. Beginning on 08/01/2019, the Social Service staff (Social Workers) will use Jefferson Inn Notify Resident' s Representative/Bed Hold Checklist to verify that a written notification has been mailed to the resident 's representative of any transfer to any hospital when a resident is admitted, weekly. Any deficiencies found will be reported to the Social Services Supervisor weekly. Beginning 08/01/2019, the Social Workers will use the Jefferson Inn Notify Resident 's Representative/Bed Hold Checklist weekly for 90 days, then bi-weekly for 60 days, then monthly for 1 month to verify that residents and resident 's representatives are receiving the facility' s written notification when there is a transfer to the hospital or when the resident is on therapeutic leave. Jaquith Nursing Home Social Services Supervisor sends a monthly report to the State Long-Term Care Ombudsman using the Monthly List of Transfers from Long Term Care (LTC) to State Ombudsman Log. The Social Services Supervisor will report findings weekly to the Administrator. D. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance will be put into place?	

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F 623	Continued From page 5	F 623	If any deficiencies are found in the documented checklist for notifying resident's representatives, the Social Workers will be re-educated and corrective actions will be taken by the Social Services Supervisor. The Social Services Supervisor will report findings to the Jefferson Inn Nursing Home Administrator (NHA) weekly. The NHA will report to the Jaquith Nursing Home (JNH) monthly Executive Committee Meeting and the Quality Assurance Performance Improvement (QAPI) Facility Committee the progress and effectiveness of the corrected actions. Should systemic changes not be effective QAPI will investigate and determine further action(s) to be implemented.	
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a	F 625		9/3/19

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F 625	Continued From page 6 resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to notify the Resident Representative of the facility bed hold policy following transfer to the hospital for one (1) of two (2) residents reviewed, Resident #69. Findings include: Review of facility policy titled "Hospital or Therapeutic Leave Bed Hold Policy" dated April 2018, revealed the facility will provide each resident and his/her resident representative notice of the facility's policy regarding the holding of a resident's bed at the time of admission and when he/she goes on leave from the facility. This policy applied to all residents of the facility. Record review of a Physician's Order revealed Resident #69 was sent to the hospital on 6/28/19, and returned to the facility on 7/1/19. Record Review of Resident #69's chart revealed there was no bed hold policy/letter provided to Resident #69 or their Resident Representative at the time Resident #69 was transferred to the hospital.	F 625	A. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? On, 07/25/2019, the Social Worker reviewed Resident #69' s medical record for notification of Bed Hold Policy. On 08/12/2019, the Social Worker mailed the resident 's representative notification of the facility' s bed hold policy and provided the resident with a copy of the letter. B. How will you identify other residents having the potential to be affected by the same deficient practice, and what corrective actions(s) will be taken? On 07/25/2019, the Jefferson Inn Nursing Home Administrator and Social Workers reviewed the census, four of 73 residents had the potential to be affected by the deficient practice. No others were affected.	

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F 625	Continued From page 7 An interview on 07/25/19 at 10:45 AM, with Resident #69's next of kin, revealed the Social Worker had been great to call and tell her when Resident #69 has gone out, but she had never received a letter from anyone about her going to the hospital, nor received a letter about the bed hold. She stated, "I certainly would have remembered that because I would be afraid they were not going to let my niece go back there. I would have called them quick and ask about what they were talking about". An interview on 07/25/19 at 11:53 AM, with the Social Worker revealed she did not send Resident #69's Resident Representative a bed hold letter when she was transferred to the hospital. An interview on 07/25/19 at 03:45 PM, with the facility Administrator, revealed "To my knowledge, we don't send a letter to notify the Resident Representative of a bed hold if a resident goes to the hospital".	F 625	C. What measures will be put into place, or what systemic changes will you make to ensure that the deficient practice does not recur? Beginning 08/01/2019, the Administrator and Social Services Director in-serviced the Social Workers and Director of Nursing(DON) addressing the circumstances regarding the facility Bed Hold Policy. The Social Workers and Director of Nursing were instructed that the resident and resident' s representative will be presented with a written notice which specifies the duration of the bed hold during the time of transfer for hospitalization or therapeutic leave. On 08/05/2019, all resident records were reviewed for notification of bed hold policy by the Administrator. On 08/05/2019, corrective actions were taken on four residents by the Social Workers to provide Bed Hold notices to the resident and resident' s representative on residents that were transferred to the hospital or on therapeutic leave. Beginning 08/01/2019, the Social Workers will use the Jefferson Inn Notify Resident' s Representative/Bed Hold Checklist weekly for 90 days, then bi-weekly for 60 days, then monthly for 1 month to verify that residents and resident' s representatives are receiving the facility' s Bed Hold Policy when there is a transfer to the hospital or when the resident is on therapeutic leave. The Social Services	

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F 625	Continued From page 8	F 625	Supervisor will report findings weekly to the Administrator. D. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance will be put into place? If any deficiencies are found in the documented checklist for notifying resident's representatives, the Social Workers will be re-educated and corrective actions will be taken by the Social Services Supervisor. The Social Services Supervisor will report findings to the Jefferson Inn Nursing Home Administrator (NHA) weekly. The NHA will report to the Jaquith Nursing Home (JNH) monthly Executive Committee Meeting and the Quality Assurance Performance Improvement (QAPI) Facility Committee the progress and effectiveness of the corrected actions. Should systemic changes not be effective QAPI will investigate and determine further action(s) to be implemented.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician.	F 657		9/3/19

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F 657	Continued From page 9 (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to revise the Percutaneous Endoscopic Gastrostomy (PEG) Care Plan to reflect the resident frequently slumps in the bed and required more frequent checks for positioning to help prevent aspiration and other complications related to continuous PEG tube feeding for one (1) of three (3) Care Plans reviewed, Resident #9. Findings include: A review of a document provided by the facility Administrator revealed the facility does not have a policy regarding care plans, enteral feedings, and positioning body alignment. The document noted that Nursing staff refer to the Lippincot Manual of Nursing Procedures (Seventh Edition) for	F 657	A. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? On 07/26/2019, the Director of Nursing (DON) reviewed the Care Plan of Resident#9. On 07/26/2019, the Minimum Data Set (MDS) Nurse was in-serviced by the DON to update care plan to reflect individualized needs and interventions for frequent checks of resident' s positioning in bed due to Resident#9 diagnosis of Huntington Disease to help prevent aspiration and other complications related to continuous Percutaneous Endoscopic Gastrostomy (PEG).	

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F 657	Continued From page 10 procedural steps for the following: Care Plans, Enteral Feeding, and Positioning Body Alignment. This was signed by the Administrator and dated 7/25/19. A review of the document provided by facility Administrator, who stated that the document was pages from the Lippincot Manuel and were used as guidelines in Percutaneous Endoscopic Gastrostomy (PEG) care and creating Care Plans, revealed, "A care plan directs the patient's nursing care from admission to discharge. This written action plan is based on nursing diagnosis that have been formulated after reviewing assessment findings. Update and revise the plan throughout the patient's stay based on the patient's response. The document noted, "Have the patient sit or maintain the head of the bed at an elevation of at least 30 degrees (45 degrees is preferred) unless contraindicated by the patient's condition to prevent esophageal reflux and pulmonary aspiration of the feeding formula. The document also revealed to elevate the head of the bed a minimum of 30 degrees, preferably 45 degrees, to manage enteral tube feeding problems. The document also revealed various assistive devices can be used to maintain correct body alignment and to help prevent complications that commonly arise when a patient must be on prolonged bed rest. A review of the article titled "Nutrition and Huntington's Disease" dated 2010, released by the Huntington's Disease society of America revealed, to "position the person so that he/she is sitting up, or at least so the upper body is above the level of the stomach". Record Review of the current Care Plan revealed	F 657	B. How will you identify other residents having the potential to be affected by the same deficient practice, and what corrective actions(s) will be taken? On 07/26/2019, the DON and MDS Nurse determined by the census that four of 73 residents with enteral feeding had the potential to be affected by the deficient practice and no others were affected. On 07/26/2019, corrective actions were taken and the MDS Nurse updated Resident #9's Care Plan to meet individualized needs. C. What measures will be put into place, or what systemic changes will you make to ensure that the deficient practice does not recur? On 07/26/2019, the DON in-serviced and re-educated the MDS Nurse on updating care plans to meet each individualized resident s need. The MDS Nurse was instructed to ensure the interventions were implemented, monitored, and documented. On 08/09/2019, Resident#9 was discontinued from continuous PEG Tube feeding and placed on Bolus PEG feeding to prevent aspiration and other complications related to continuous PEG tube feeding. Care plans in accordance with the care plan review schedule will be reviewed weekly by the MDS Nurse and	

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F 657	Continued From page 11 Resident #9 was admitted to Hospice for a diagnosis of Huntington's disease. Resident #9's care plan documented a problem of totally dependent x two (2) persons for bed mobility, and a high risk for aspiration and choking related to PEG tube placement, and Huntington's disease. The Care Plan documented to reposition every two (2) hours and as needed. The Care plan did not document any interventions or frequent checks related to Resident #9's frequent repositioning ability to get herself flat in the bed. Observations on 07/23/19 at 09:55 AM, 7/24/19 at 8:21 AM, and 7/24/19 at 3:15 PM, revealed Resident #9 lying in bed. Two Cal 2.0 feeding formula was infusing at 45 cubic centimeters per hour (cc/hr) via feeding pump. The head of Resident #9's bed frame was elevated at approximately 20 degrees and 45 degrees. There was a wide wedge at the head of the bed located under the sheet with a pillow on top of the wedge on the outside of the sheet. Resident #9's body was slumped down in the bed at a flat angle on all three (3) occasions and/or with the upper body at the same angle as the stomach. An observation on 07/25/19 at 06:55 AM, revealed Resident #9 was lying in bed with her head towards the right side of the bed railing and off the pillow and wedge. Two Cal 2.0 was infusing continuously at 45 cc/hr via feeding pump. Resident #9's legs were lying towards the left side of the bed railing with the head of bed (HOB) at approximately 45 degrees. Resident #9's body was slumped down in the bed with her left shoulder slightly elevated with edge of the pillow with the upper body at the same angle of the stomach. Licensed Practical Nurse (LPN) #1 entered Resident #9's room and the feeding	F 657	DON. All care plans will be updated as indicated. Beginning 08/09/2019, the DON or Registered nursing staff will complete random weekly audits of five (5) care plans for four (4) consecutive weeks then ongoing monthly. Random audits will be completed to ensure that comprehensive care plans are developed and individualized for residents. D. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance will be put into place? Findings of this audit will be discussed with the Jefferson Inn Nursing Home Administrator (NHA) weekly. The NHA will report to the Jaquith Nursing Home (JNH) monthly Executive Committee Meeting and the Quality Assurance Performance Improvement (QAPI) Facility Committee the progress and effectiveness of the corrected actions. Should systemic changes not be effective QAPI will investigate and determine further action(s) to be implemented.	

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F 657	Continued From page 12 pump was beeping. LPN #1 stated that Resident #9 was always slumped to the right side of the bed because the resident had End Stage Huntington's Disease and that was how she always lay in bed. LPN #1 stated that Resident #9 always moved around in bed as part of her Huntington's. During an interview on 07/25/19 at 03:15 PM, the Director of Nursing (DON) stated, "The Care Plan is an on-going plan of care for a resident. You should be able to read the care plan and know what to do for a resident. We are supposed to do everything for our residents. I can't say yes or no that positioning of Resident #9 should be revised on the care plan. We can straighten Resident #9 up in bed and she gets into positions herself. I'll see what therapy can offer for her". During an interview on 07/25/19 at 04:15 PM, RN #3, Care Plan Nurse, revealed that a care plan is a plan to be able to care for a resident. RN #3 stated that Resident #9 positioning down in the bed makes the resident a high risk for aspiration with continuous tube feeding. She stated, "The Care Plan should be revised to add positioning issues and interventions to help with positioning". RN #3 stated that Resident #9 also has End Stage Huntington's Disease and that too would make her a high risk for aspiration. RN #3 stated that she felt the Enteral Feeding Care Plan should be revised for maybe 15 minute checks because of the Huntington's disease and the spasmodic movements caused by that disease. RN #3 revealed that "Any nurse who takes care of a resident should be able to look at a care plan and know exactly what a resident needs. The Care Plan just should have been revised. I will contact the physician and see what he thinks	F 657		

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F 657	Continued From page 13 about therapy".	F 657		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to position a resident who received Percutaneous Endoscopic Gastrostomy (PEG) tube feedings to help prevent complications such as aspiration for one (1) of three (3) residents reviewed for positioning, Resident #9. Findings include:	F 693	A. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? On 07/26/2019, the Director of Nursing (DON) reviewed Resident#9' s chart. On 07/26/2019, Corrective actions were taken and Resident#9 was placed on 15 minute time check observation for safety	9/3/19

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F 693	Continued From page 14 A review of a document provided by the facility Administrator revealed the facility does not have a policy regarding enteral feedings and positioning body alignment. The document noted that Nursing staff refer to the Lippincot Manual of Nursing Procedures (Seventh Edition) for procedural steps for Enteral Feeding and Positioning Body Alignment. This was signed by the Administrator and dated 7/25/19. A review of a document, provided by the Administrator, revealed the document was pages from the Lippincot Manuel and were used as guidelines in Percutaneous Endoscopic Gastrostomy (PEG) care. The document noted, "Have the patient sit or maintain the head of the bed at an elevation of at least 30 degrees (45 degrees is preferred) unless contraindicated by the patient's condition to prevent esophageal reflux and pulmonary aspiration of the feeding formula. The document also revealed to elevate the head of the bed a minimum of 30 degrees, preferably 45 degrees, to manage enteral tube feeding problems. The document also revealed various assistive devices can be used to maintain correct body alignment and to help prevent complications that commonly arise when a patient must be on prolonged bed rest. A review of the article titled "Nutrition and Huntington's Disease", dated 2010, released by the Huntington's Disease society of America revealed, to "position the person so that he/she is sitting up, or at least so the upper body is above the level of the stomach". A review of the article titled "Oral feeding in Huntington's Disease: a guideline document for speech and language therapists" dated 2012,	F 693	measures and positioning related to Huntington 's Disease. B. How will you identify other residents having the potential to be affected by the same deficient practice, and what corrective actions(s) will be taken? On 07/26/2019, the DON and the Minimum Data Set (MDS) Nurse reviewed charts and determined by census four of 73 residents had the potential to be affected by the deficient practice, no others were affected. C. What measures will be put into place, or what systemic changes will you make to ensure that the deficient practice does not recur? On 07/26/2019, Occupational Therapy was consulted for positioning devices to aid in maintaining proper positioning while in bed for Resident#9. On 08/09/2019, Speech Therapy was consulted for evaluation and possible treatment. On 08/09/2019, Resident#9 was discontinued from continuous PEG Tube feeding and placed on Bolus PEG feeding to prevent aspiration and other complications related to continuous PEG tube feeding. Beginning 08/13/2019, the DON in-serviced the Jefferson Inn's Certified Nursing Assistants(CNA) on the Time Check Observation Report Mississippi State Hospital(MSH)31A on proper	

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F 693	Continued From page 15 revealed, "Involuntary movements create increasing difficulties in Late stage Huntington's Disease. Dietary modifications, the use of compensatory swallowing techniques, the manipulation of head or body postures and maneuvers to support safe and efficient swallowing should continue. All caregivers should be in receipt of specific instructions on positioning and postures. Regular monitoring of the individual with Huntington's Disease weight, hydration, nutrition and occurrence of aspiration pneumonia is a key at this stage in the disease. An observation on 07/23/19 at 09:55 AM, revealed Resident #9 lying in bed. Two Cal 2.0 feeding formula was infusing at 45 cubic centimeters (cc) per (/) hour (hr) via feeding pump. The head of Resident #9's bed frame was elevated at approximately 20 degrees. There was a wide wedge at the head of the bed located under the sheet with a pillow on top of the wedge on the outside of the sheet. The Resident's head was lying off of the pillow and wedge against the right side rails of the bed. Resident #9's body was slumped down in the bed at a flat angle. An observation on 07/24/19 at 08:21 AM, revealed Resident #9 was lying in the bed with her head off the pillow and wedge. Resident #9 body was slumped down in the bed with her left shoulder slightly elevated in the bed by the edge of the pillow with the upper body at the same angle as to stomach. Two Cal 2.0 feeding was continuously infusing at 45 cc/hr via feeding pump. The head of bed (HOB) was approximately 45 degrees. An observation at 7/24/19 at 03:15 PM, revealed Resident #9 was lying in bed. The HOB was	F 693	documentation on visual observation of Resident#9 positioning and the importance of positioning due to a risk for aspiration related to Huntington's disease. Beginning 08/14/2019, the MDS Nurse will monitor the MSH Time Check Observation Report (MSH31A) to ensure staff is monitoring Resident#9 for proper positioning to help prevent aspiration and other complications related to Huntington' s Disease daily for two (2) weeks then weekly for four (4) weeks and report daily to stand up team any discrepancies. D. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance will be put into place? Findings of this audit will be discussed with the Jefferson Inn Nursing Home Administrator (NHA) weekly. The NHA will report to the Jaquith Nursing Home(JNH) monthly Executive Committee Meeting and the Quality Assurance Performance Improvement (QAPI) Facility Committee the progress and effectiveness of the corrected actions. Should systemic changes not be effective QAPI will investigate and determine further action(s) to be implemented.	

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F 693	Continued From page 16 elevated at 45 degrees. There was a wide wedge at the head of the bed located under the sheet with a pillow on top of the wedge on the outside of the sheet. Resident #9's body was slumped down in the bed with her head at the right side of the bed against the side rails. Resident #9's head was off the pillow and the wedge and her body was at a flat angle in bed. Two Cal was continuously infusing at 45 cc/hr via PEG tube. An observation on 07/25/19 at 06:55 AM, revealed Resident #9 was lying in bed with her head towards the right side of the bed railing and off of the pillow and wedge, with Two Cal 2.0 infusing continuously at 45 cc/hr via feeding pump. Resident #9's legs were lying towards the left side of the bed railing with the head of bed (HOB) at approximately 45 degrees. Resident #9's body was slumped down in the bed with her left shoulder slightly elevated with the edge of the pillow with the upper body at the same angle of the stomach. Licensed Practical Nurse (LPN) #1 entered Resident #9's room and the feeding pump was beeping. LPN #1 stated that Resident #9 "is always slumped to the right side of the bed". LPN #1 stated that Resident #9 had End Stage Huntington's Disease and that was how she always lay in bed. LPN #1 stated that Resident #9 "always moves around in bed. That's part of her Huntington's". An interview on 07/25/19 at 03:15 PM, with the Director of Nursing (DON), revealed "We are supposed to do everything for our residents...We can straighten Resident #9 up in bed and she gets into positions herself. I'll see what therapy can offer for her". An interview on 07/25/19 at 04:15 PM, with RN	F 693		

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F 693	Continued From page 17 #3, Care Plan Nurse, revealed that Resident #9 positioning down in the bed makes her a high risk for aspiration with the continuous formula feeding. RN #3 stated that Resident #9 also has End Stage Huntington's Disease and that too would make her a high risk for aspiration.	F 693		
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 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	F 880		9/3/19

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F 880	Continued From page 18 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. §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, record review, and facility policy review, the facility failed to prevent the possible spread of infection by not	F 880	A. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient	

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F 880	Continued From page 19 washing hands and changing gloves during Percutaneous Endoscopic Gastrostomy (PEG) care for two (2) of three (3) resident observations for PEG care, Resident #9 and Resident #22. Findings include: A review of facility policy titled "Infection Prevention Policies, Procedures and Protocol" dated August 2018, revealed policy, procedures, and protocols will be based on state and federal statutes, recommendations from the Center of Disease Control (CDC), the Joint Commission and Association for Professionals in Infection Control and on acceptable standards of medical care". A review of facility policy titled "HandHygiene", dated April 2019, revealed: The policy provides guidelines and procedures to prevent the direct or indirect spread of infection. Hand hygiene is the single most important factor for preventing the spread of healthcare associated infections. This policy applies to all programs of the facility. It is the policy that all employees will use proper hand hygiene techniques to prevent the spread of infectious disease. Personnel should always cleanse/sanitize their hands; before and after touching wounds, before and between each patient/resident, after removing gloves, after touching objects that may be contaminated with disease causing microorganisms, when moving from a contaminated body site to a clean body site on the same patient/resident, before caring for patients/residents with neutropenia or other immune suppressions and after contact with inanimate objects in the vicinity of the patient/resident.	F 880	practice? On 07/25/2019, the Director of Nursing (DON) re-educated Registered Nurse(RN)#1 and Licensed Practical Nurse(LPN)#1 on the proper Percutaneous Endoscopic Gastrostomy (PEG) Care and Hand Hygiene Protocol. On 07/25/2019, the DON reviewed Resident#9 and Resident#22 charts for findings of any signs and symptoms of infections. On 07/25/2019, the Minimum Data Set (MDS) Nurse assessed Resident#9 and Resident#22 for any signs and symptoms of infection. No negative findings were noted. B. How will you identify other residents having the potential to be affected by the same deficient practice, and what corrective actions(s) will be taken? On 07/25/2019, Jefferson Inn DON reviewed the census and identified four of 73 residents receiving PEG Care had the potential to be affected and two were affected. On 07/25/2019, the DON implemented the Jefferson Inn PEG Site Dressing Change Checklist that emphasizes when removing gloves, perform hand hygiene to prevent the possible spread of infection while performing PEG Care. C. What measures will be put into place, or what systemic changes will you make	

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F 880	Continued From page 20 An observation on 07/25/19 at 6:55 AM, revealed Licensed Practical Nurse (LPN) #1 entered Resident #9's room and the feeding pump was beeping. Resident #9 was slumped to the right side of the bed. LPN #1 put on gloves, without washing her hands, and checked the feeding pump. LPN #1 touched the pump and the Percutaneous Endoscopic Gastrostomy (PEG) tubing at Resident #9's stoma site. LPN #1 picked the garbage can up and placed it by Resident #9's bedside. LPN #1 removed her gloves and washed her hands. LPN #1 had set her tote containing her supplies (gauze, normal saline, hand sanitizer, drain gauze, disposable bed pad, tape and box of gloves) on the over-bed table when she entered the room earlier. LPN #1 accidentally bumped the over-bed table and the box of gloves fell out of the tote onto the floor. LPN #1 reached down and picked up the box of gloves and placed them back into the tote with the other clean supplies. LPN #1 gloved, without washing her hands, picked up the tote that she had her supplies in, and wiped Resident #9's over-bed table with disinfectant wipes. LPN #1 allowed the area to dry approximately one (1) minute still holding the tote in her hand. LPN #1, still wearing the gloves, reached into the tote and moved the box of gloves that she had picked up off the floor, around in the tote. LPN #1 picked up a blue disposable bed pad out of the tote and laid it on the over-bed table as a barrier. LPN #1 removed her gloves and used hand sanitizer to clean her hands. LPN #1 gloved and opened four (4) gauze packages and laid them on the barrier in the packaging. LPN #1 reached over into the tote and moved the contaminated box of gloves around in the tote. LPN #1 removed the dirty dressing from Resident #9's stoma and discarded the dressing into a red biohazard bag along with	F 880	to ensure that the deficient practice does not recur? On 07/25/2019, the DON immediately in-serviced RN#1 and LPN#1 on Infection Prevention Policy (IP162-66) Hand Hygiene Infection Prevention when performing PEG Care and Jefferson Inn PEG Site Dressing Change Checklist. Beginning 07/26/2019, the DON in-serviced all Jefferson Inn Licensed Nurses on Hand Hygiene Infection Prevention when performing PEG Care and Jefferson Inn PEG Site Dressing Change Checklist. Beginning 08/09/2019, the DON will observe and audit a Licensed Nurse using the Jefferson Inn PEG Site Dressing Change Checklist for four (4) weeks then every two (2) weeks for eight (8) weeks to verify for proper hand hygiene during and after PEG Care. The findings for each observation will be documented on the PEG Site Dressing Change Checklist. Any deficiencies noted from the observation will be corrected promptly by the DON. The DON will report all deficiencies to the Nursing Home Administrator weekly. D. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance will be put into place? If any deficiencies are found in the documented checklist for PEG Site Dressing Change Checklist, the Licensed Nurses will be re-educated and corrective	

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F 880	Continued From page 21 her gloves. LPN #1 washed her hands, dried her hands with a paper towel and laid paper towel on the sink. LPN #1 took another paper towel, turned the faucet off, and then picked up dirty paper towel in clean hands and discarded them into the garbage can at the bedside. LPN #1 gloved, obtained the bottle of normal saline out of the tote and poured the normal saline onto the gauze in the paper containers. LPN #1 used one (1) gauze, while holding the tubing at the stoma site, and wiped in a circular motion around stoma folding the gauze over at one point double wiping the stoma site. LPN #1 discarded the dirty gauze into the red bag. After completing the care, LPN #1 dried the area around the stoma. LPN #1 removed her gloves and without washing or sanitizing her hands, applied another pair of gloves. LPN #1 opened a split drain dressing packet and applied the clean dressing to the stoma. LPN #1 secured the dressing to the stoma site with one piece of tape. An interview on 07/25/19 at 7:27 AM, with LPN #1, revealed, "I didn't realize I folded the gauze over. I was nervous. I remember not washing my hands between cleaning the stoma site and applying a clean dressing clean. I changed my gloves but didn't wash my hands before applying gloves. I remember dropping the box of gloves on the floor. I should have discarded them and not used them. They would be considered contaminated. I should have went and got another box". An interview on 07/25/19 at 3:00 PM, with RN #2, Infection Control Nurse, revealed, "Improper hand hygiene is an infection control issue. We do teach hand hygiene here. We show two (2) videos from the Center for Disease Control (CDC) in	F 880	actions will be taken by the DON. The DON will report findings to the Jefferson Inn Nursing Home Administrator (NHA) weekly. The NHA will report to the Jaquith Nursing Home (JNH) monthly Executive Committee Meeting and the Quality Assurance Performance Improvement (QAPI) Facility Committee the progress and effectiveness of the corrected actions. Should systemic changes not be effective QAPI will investigate and determine further action(s) to be implemented.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A402	A. BUILDING _____ B. WING _____	07/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JNH-JEFFERSON INN	3550 HWY 468 WEST - PO BOX 207 BLDG 33 WHITFIELD, MS 39193

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F 880	Continued From page 22 orientation. We teach to wash your hands before and after care is provided. We have in-services monthly. The box of gloves falling onto the floor is considered as contaminated. The nurse should have got another box of gloves and not used those. That is an infection control issue as well". An interview on 07/25/19 at 3:15 PM, with the Director of Nursing (DON), revealed, "Anytime you remove your gloves you should wash your hands or use sanitizer. Anytime you go from dirty to clean you should do hand hygiene of some sort. But, definitely any time you remove gloves, you need to perform hand hygiene. Not performing proper hand hygiene when providing care is an infection control issue. When the LPN dropped the gloves on the floor, she should have left them on the floor and went and got some more". Review of a Continuing Education sign-in-sheet titled "Hand Hygiene; Wearing gloves and changing and sanitation in between resident to resident" revealed LPN #1 was in attendance on 9/27/18, for the inservice on Hand Hygiene. Resident #22 An observation on 07/24/19 at 9:20 AM, revealed Registered Nurse (RN) #1 entered Resident #22's room with clean supplies in a tote. RN #1 sat the tote with the supplies in it on the over-bed table. RN #1 washed her hands and applied gloves and used sanitizing wipes to clean the top of the over bed table. RN #1 allowed the over bed table to dry for approximately three (3) minutes. RN #1 removed her gloves, washed her hands, and removed Resident #22's blanket with clean hands. RN #1 gloved, without washing her hands, and laid a disposable blue pad on the	F 880		

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F 880	Continued From page 23 over-bed table as a barrier, removed the supplies from the tote, and laid them onto the barrier. RN #1 opened the normal saline and sit the open bottle on the barrier with lid off. RN #1 re-gloved and took out a red biohazard bag, opened the bag, and put it on the end of the over-bed table. RN #1 took her gloves off and applied tape to the red bag securing it to the over bed table. RN #1 opened the gauze packets with her bare hands touching the gauze with her fingers. RN #1 reached and picked up the bottle of normal saline with her bare hands and poured it over opened gauze lying in packets on the over bed table. RN #1 gloved, removed the dirty dressing from the stoma site, and discarded the dressing in the biohazard bag. RN #1 removed her gloves and donned new gloves, picked up the gauze with normal saline on it, and wiped in a circular motion around the stoma site. RN #1 discarded the dirty gauze in the biohazard bag. RN #1 removed her gloves and gloved again without washing hands. RN #1 repeated the procedure using a second gauze covered with normal saline. RN #1 obtained a dry gauze and dried the area in a circular motion and then discarded the gauze in the biohazard bag. RN #1 removed her gloves and applied new gloves without washing her hands. RN #1 opened the drain sponge dressing package and applied the clean dressing to the stoma. RN #1 secured the tubing at the stoma site with her hand, obtained a gauze that had normal saline on it, and wiped the tubing from the stoma towards the pump. RN #1 discarded the dirty gauze and without washing her hands and changing her gloves, RN #1 picked up a dry gauze, secured the tubing with her hand and wiped the tubing upwards toward the pump. RN #1 discarded supplies and washed hands.	F 880		

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F 880	Continued From page 24 An interview on 07/24/19 at 10:00 AM, with RN #1, revealed that she should have washed her hands after cleaning the stoma and before applying a new dressing. RN #1 stated that she should have washed her hands after cleaning the PEG tubing and before drying the tubing. RN #1 stated that "just changing gloves would not necessary prevent an infection and you never know when there might be a pin hole in the gloves. I guess I did leave the normal saline open. I didn't realize it, I was so nervous". An interview on 07/25/19 at 3:00 PM, with RN #2, Infection Control Nurse, revealed, "Improper hand hygiene is an infection control issue. We do teach hand hygiene here. We show two (2) videos from the Center for Disease Control (CDC) in orientation. We teach to wash your hands before and after care is provided. We have in-services monthly". An interview on 07/25/19 at 3:15 PM, with the Director of Nursing (DON), revealed, "Anytime you remove your gloves you should wash your hands or use sanitizer. Anytime you go from dirty to clean you should do hand hygiene of some sort. But, definitely after removing any gloves you need to perform hand hygiene. Not performing proper hand hygiene when providing care is an infection control issue". A Review of the document dated 7/26/19, provided by RN #2, revealed RN #1 was in attendance for the Infection Prevention (IP) inservice on 2/6/19.	F 880		

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	25A402	A. BUILDING **01 - BUILDINGS 33** B. WING _____	**07/23/2019**

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JNH-JEFFERSON INN	**3550 HWY 468 WEST - PO BOX 207 BLDG 33** **WHITFIELD, MS 39193**

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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 | 08/14/2019

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.

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E 000	Initial Comments ********** Survey conducted on 07/23/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were cited.	E 000		

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

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