MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	61AD	A. BUILDING: _____ B. WING _____	06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JNH-ADAMS INN	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) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted a recertification survey from 06/10/19 to 06/13/19. During the survey the SA determined the facility was not in compliance with the Minimum Standards for The Institutions For The Aged And Infirm. The SA cited the state statutes M500, M780, and M1010. The census at the time of entrance was 47, and the facility was certified for 59 beds. The State Agency (SA) determined during an annual recertification survey conducted on June 10, 2019, the facility was in compliance for State Licensure requirements. No deficiencies were cited.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility,	M 500		8/6/19

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	61AD	A. BUILDING: _____ B. WING _____	06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JNH-ADAMS INN	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) COMPLETE DATE
M 500	Continued From page 1 and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	61AD	A. BUILDING: _____ B. WING _____	06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JNH-ADAMS INN	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) COMPLETE DATE
M 500	Continued From page 2 established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	61AD	A. BUILDING: _____ B. WING _____	06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JNH-ADAMS INN	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) COMPLETE DATE
M 500	Continued From page 3 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	61AD	A. BUILDING: _____ B. WING _____	06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JNH-ADAMS INN	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) COMPLETE DATE
M 500	Continued From page 4 personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level II Based on observation, resident and staff interview, record review, and review of facility policy, the facility failed to ensure the residents' right to be free from the use of physical restraints. 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 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:	M 500	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 Minimum Data Set nurse on June 13, 2019. 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	61AD	A. BUILDING: _____ B. WING _____	06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JNH-ADAMS INN	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) COMPLETE DATE
M 500	Continued From page 5 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 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	M 500	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 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	61AD	A. BUILDING: _____ B. WING _____	06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JNH-ADAMS INN	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) COMPLETE DATE
M 500	Continued From page 6 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 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	M 500	material on the Federal regulation Ftag 604 on 6/26/2019. a. 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 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 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	61AD	A. BUILDING: _____ B. WING _____	06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JNH-ADAMS INN	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) COMPLETE DATE
M 500	Continued From page 7 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 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	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	61AD	A. BUILDING: _____ B. WING _____	06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JNH-ADAMS INN	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) COMPLETE DATE
M 500	Continued From page 8 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 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	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	61AD	A. BUILDING: _____ B. WING _____	06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JNH-ADAMS INN	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) COMPLETE DATE
M 500	Continued From page 9 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; 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.	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	61AD	A. BUILDING: _____ B. WING _____	06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JNH-ADAMS INN	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) COMPLETE DATE
M 500	Continued From page 10 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, 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	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	61AD	A. BUILDING: _____ B. WING _____	06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JNH-ADAMS INN	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) COMPLETE DATE
M 500	Continued From page 11 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 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	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	61AD	A. BUILDING: _____ B. WING _____	06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JNH-ADAMS INN	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) COMPLETE DATE
M 500	Continued From page 12 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 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	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	61AD	A. BUILDING: _____ B. WING _____	06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JNH-ADAMS INN	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) COMPLETE DATE
M 500	Continued From page 13 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 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." The CNA stated they went ahead and put the pelvic restraint on him anyway. 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	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	61AD	A. BUILDING: _____ B. WING _____	06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JNH-ADAMS INN	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) COMPLETE DATE
M 500	Continued From page 14 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 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, 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	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	61AD	A. BUILDING: _____ B. WING _____	06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JNH-ADAMS INN	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) COMPLETE DATE
M 500	Continued From page 15	M 500		

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 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	61AD	A. BUILDING: _____ B. WING _____	06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JNH-ADAMS INN	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) COMPLETE DATE
M 500	Continued From page 16 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 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	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	61AD	A. BUILDING: _____ B. WING _____	06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JNH-ADAMS INN	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) COMPLETE DATE
M 500	Continued From page 17 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, 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.	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	61AD	A. BUILDING: _____ B. WING _____	06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JNH-ADAMS INN	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) COMPLETE DATE
M 500	Continued From page 18 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 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	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	61AD	A. BUILDING: _____ B. WING _____	06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JNH-ADAMS INN	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) COMPLETE DATE
M 500	Continued From page 19 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 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	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	61AD	A. BUILDING: _____ B. WING _____	06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JNH-ADAMS INN	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) COMPLETE DATE
M 500	Continued From page 20 "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 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 nonsense talk. When someone talked to her, Resident #21 reacted as if she thought they had accused her. If there were enough staff to supervise her there is a good chance to take the restraints off Resident #21. 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,	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	61AD	A. BUILDING: _____ B. WING _____	06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JNH-ADAMS INN	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) COMPLETE DATE
M 500	Continued From page 21 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 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	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	61AD	A. BUILDING: _____ B. WING _____	06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JNH-ADAMS INN	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) COMPLETE DATE
M 500	Continued From page 22 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 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	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	61AD	A. BUILDING: _____ B. WING _____	06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JNH-ADAMS INN	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) COMPLETE DATE
M 500	Continued From page 23 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 thefacility 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 a restraint and alternatives attempted as planned in the care plan, to include monthly assessments. The MDS Coordinator was unable to produce the monthly 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. When questioned regarding attempts at lesser restrictive devices the Physician responded, if the facility had more staff it might be possible to take off some of the physical restraints. 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	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	61AD	A. BUILDING: _____ B. WING _____	06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JNH-ADAMS INN	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) COMPLETE DATE
M 500	Continued From page 24 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 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	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	61AD	A. BUILDING: _____ B. WING _____	06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JNH-ADAMS INN	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) COMPLETE DATE
M 500	Continued From page 25 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.	M 500		
M 780	45.27.2 Activity Program Activity Program. Provisions shall be made for suitable recreational and entertainment activities for resident according to their needs and interests. These activities are an important adjunct to daily living and are to encourage restoration to self-care and resumption of normal activities. Variety in planning shall include some outdoor activities in suitable weather. Level II 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	M 780	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.	8/6/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	61AD	A. BUILDING: _____ B. WING _____	06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JNH-ADAMS INN	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) COMPLETE DATE
M 780	Continued From page 26 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 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.	M 780	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 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	61AD	A. BUILDING: _____ B. WING _____	06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JNH-ADAMS INN	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) COMPLETE DATE
M 780	Continued From page 27 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 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	M 780	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 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	61AD	A. BUILDING: _____ B. WING _____	06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JNH-ADAMS INN	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) COMPLETE DATE
M 780	Continued From page 28 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 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	M 780	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 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 choos 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	61AD	A. BUILDING: _____ B. WING _____	06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JNH-ADAMS INN	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) COMPLETE DATE
M 780	Continued From page 29 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 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	M 780	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 to be implemented. The corrected actions were completed on 8/6/19.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	61AD	A. BUILDING: _____ B. WING _____	06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JNH-ADAMS INN	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) COMPLETE DATE
M 780	Continued From page 30	M 780		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	61AD	A. BUILDING: _____ B. WING _____	06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JNH-ADAMS INN	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) COMPLETE DATE
M 780	Continued From page 31 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 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	M 780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	61AD	A. BUILDING: _____ B. WING _____	06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JNH-ADAMS INN	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) COMPLETE DATE
M 780	Continued From page 32 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 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	M 780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	61AD	A. BUILDING: _____ B. WING _____	06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JNH-ADAMS INN	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) COMPLETE DATE
M 780	Continued From page 33 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 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	M 780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	61AD	A. BUILDING: _____ B. WING _____	06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JNH-ADAMS INN	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) COMPLETE DATE
M 780	Continued From page 34 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 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	M 780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	61AD	A. BUILDING: _____ B. WING _____	06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JNH-ADAMS INN	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) COMPLETE DATE
M 780	Continued From page 35 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 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	M 780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	61AD	A. BUILDING: _____ B. WING _____	06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JNH-ADAMS INN	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) COMPLETE DATE
M 780	Continued From page 36 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 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.	M 780		
M1010	45.35.1 Housekeeping Facilities and Services Housekeeping Facilities and Services. 1. The physical plant shall be kept in good repair, neat, and attractive. The safety and comfort of the resident shall be the first consideration. 2. Janitor closets shall be provided with a mop-cleaning sink and be large enough in area to store house cleaning supplies and equipment. A separate janitor closet area and equipment should be provided for the food service area. This Statute is not met as evidenced by:	M1010		8/6/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	61AD	A. BUILDING: _____ B. WING _____	06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JNH-ADAMS INN	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) COMPLETE DATE
M1010	Continued From page 37 Level II 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: 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	M1010	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 mates 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 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	61AD	A. BUILDING: _____ B. WING _____	06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JNH-ADAMS INN	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) COMPLETE DATE
M1010	Continued From page 38 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 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	M1010	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. 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	61AD	A. BUILDING: _____ B. WING _____	06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JNH-ADAMS INN	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) COMPLETE DATE
M1010	Continued From page 39 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 Manage 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 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	M1010	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 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	61AD	A. BUILDING: _____ B. WING _____	06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JNH-ADAMS INN	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) COMPLETE DATE
M1010	Continued From page 40 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." 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	M1010	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 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	61AD	A. BUILDING: _____ B. WING _____	06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JNH-ADAMS INN	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) COMPLETE DATE
M1010	Continued From page 41 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) 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	M1010	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 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	61AD	A. BUILDING: _____ B. WING _____	06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JNH-ADAMS INN	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) COMPLETE DATE
M1010	Continued From page 42 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 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)	M1010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	61AD	A. BUILDING: _____ B. WING _____	06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JNH-ADAMS INN	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) COMPLETE DATE
M1010	Continued From page 43 Observation, on 06/09/19 at 1:30 PM, during the facility tour on the male hall of cognitively impaired residents residing in rooms #111to #136 revealed the following: Marked, and pealing 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. 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	M1010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	61AD	A. BUILDING: _____ B. WING _____	06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JNH-ADAMS INN	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) COMPLETE DATE
M1010	Continued From page 44 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 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.	M1010		