STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A197	A. BUILDING _____ B. WING _____	06/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JNH-JAQUITH INN	3550 HIGHWAY 468 WEST- PO BOX207/BLDG 78 WHITFIELD, MS 39193

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A standard survey was conducted at the facility from June 17, 2019 through June 20, 2019, by Ascellon, on behalf of the MS State Department of Health. The standard survey revealed that the facility was not in substantial compliance with the requirements of participation in Medicare/Medicaid. The following deficiencies resulted from the facility's noncompliance: F638, F814, and F912. The facility's census on June 17, 2019 was 57 residents and the facility held a license 58 beds.	F 000		
F 638 SS=E	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to ensure that each resident received a timely quarterly review assessment, no less than once every three (3) months, between comprehensive assessments for 19 of 19 residents identified, Residents #1- 21. Findings include: An interview was conducted with the Director of Nursing (DON) on 6/18/19 at approximately 10:44 AM. The DON stated that the Minimum Data Set (MDS) Coordinator assumed the coordinator role in May 2019. The DON noted that the facility was without an MDS nurse since March 2019.	F 638	A. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? On June 11, 2019, the Minimum Data Set (MDS) Nurse reviewed Jaquith Inn's census and revised the MDS calendar to ensure that each resident would be assessed no less than once every ninety (90) days. Resident #2 MDS assessment was completed on June 5, 2019. Data for resident's MDS assessments was compiled by the MDS Nurse prior to the start of the survey on Residents #1, #3,	7/24/19

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

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F 638	Continued From page 1 An interview was conducted with the MDS Coordinator on 6/18/19 at approximately 2:44 PM. The Coordinator noted that since she has started, she has been trying to submit all the late assessments. The Coordinator confirmed that she started in May 2019, and got about 20 MDSs completed, and they were all late. Record review revealed: a. Resident #1's last Quarterly MDS assessment was completed on 1/2/19. There were no other assessments after this date, confirming that the MDS assessment was not completed in a timely manner. b. Resident #2's last Quarterly MDS assessment was completed on 6/5/19; however, the previous quarterly MDS was completed on 1/2/19, confirming that the MDS assessment was not completed in a timely manner. c. Resident #3's last Quarterly MDS assessment was completed on 1/2/19. There were no other assessments after this date, confirming that the MDS assessment was not completed in a timely manner. d. Resident #4's last Quarterly MDS assessment was completed on 1/9/19. There were no other assessments after this date, confirming that the MDS assessment was not completed in a timely manner. e. Resident #5's last Quarterly MDS assessment was completed on 1/9/19. There were no other assessments after this date, confirming that the MDS assessment was not completed in a timely	F 638	#4, #5, #6, #7, #8, #10, #12, and #13. The above residents MDS assessments were completed on June 27, 2019. On July 3, 2019, Residents #9, #14, #15, #16, and #17 MDS assessments were completed. Residents #19 and #20 MDS assessments were completed on July 11, 2019. The MDS assessment for Resident #21 was completed on July 24, 2019 due to hospitalization. On June 20, 2019, the Director of Nursing (DON), provided and in-service to the MDS Nurse on the Resident Assessment Instrument (RAI) 3.0 Manual section 5.2 "Timeliness Criteria" chapter 5 pages 5-2 through 5-4 to address the importance of timely reviews. B. How you will identify other residents having the potential to be affected by the same deficient practice? On June 20, 2019, the MDS Nurse reviewed Jaquith Inn 's census and compared it to the MDS Calendar and found that 38 additional residents of 57 residents had the potential to be affected, but no other residents were found to be affected. C. What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur? On June 20,2019, the Jaquith Inn's Nursing Home Administrator, DON, and MDS Nurse met to decide what steps	

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F 638	Continued From page 2 manner. f. Resident #6's last Quarterly MDS assessment was completed on 1/9/19. There were no other assessments after this date, confirming that the MDS assessment was not completed in a timely manner. g. Resident #7's Admission MDS assessment was completed on 1/14/19. There were no other assessments after this date, confirming that the MDS assessment was not completed in a timely manner. h. Resident #8's Annual MDS assessment was completed on 1/16/19. There were no other assessments after this date, confirming that the MDS assessment was not completed in a timely manner. i. Resident #9's Annual MDS assessment was completed on 1/16/19. There were no other assessments after this date. j. Resident #10's last Quarterly MDS assessment was completed on 1/16/19. There were no other assessments after this date, confirming that the MDS assessment was not completed in a timely manner. k. Resident #12's last Quarterly MDS assessment was completed on 1/23/19. There were no other assessments after this date, confirming that the MDS assessment was not completed in a timely manner. l. Resident #13's last Quarterly MDS assessment was completed on 1/23/19. There were no other assessments after this date, confirming that the	F 638	would be taken to prevent a delay in timely reviews. In the absence of the Jaquith Inn's MDS Nurse, shared access will be utilized with all of the MDS nurses between the other facilities located on the Jaquith Nursing Home (JNH) campus. With shared access, each MDS Nurse will have the capability to process any resident's MDS assessment campus wide. The DON will notify the NHA and Nurse Administrator of the need for MDS assessments to be processed by other MDS nurses on JNH campus to ensure timely review criteria is achieved. Beginning June 21, 2019, Jaquith Inn 's census and MDS calendar will be reviewed and compared weekly by the MDS Nurse to confirm that each resident has been included on the MDS calendar. By implementing these practices, the MDS assessments will be reviewed and completed no less than once every ninety (90) days. During weekly interdisciplinary team (IDT) meetings, the Jaquith Inn's MDS Nurse announces each resident that is being reviewed as well as those residents scheduled for the next upcoming IDT meeting. The Jaquith Inn's MDS Nurse will give each IDT member a MDS calendar for at least sixty (60) days in advance. Any changes regarding the MDS calendar will be reported immediately to the IDT team members by the Jaquith Inn's MDS Nurse via email or discussed during the weekly IDT meeting. Any deficiencies will be reported to the DON for corrective actions.	

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F 638	Continued From page 3 MDS assessment was not completed in a timely manner. m. Resident #14's last Quarterly MDS assessment was completed on 1/30/19. There were no other assessments after this date, confirming that the MDS assessment was not completed in a timely manner. n. Resident #15's last Quarterly MDS assessment was completed on 1/30/19. There were no other assessments after this date, confirming that the MDS assessment was not completed in a timely manner. o. Resident #16's last Quarterly MDS assessment was completed on 1/30/19. There were no other assessments after this date, confirming that the MDS assessment was not completed in a timely manner. p. Resident #17's last Quarterly MDS assessment was completed on 1/30/19. There were no other assessments after this date, confirming that the MDS assessment was not completed in a timely manner. q. Resident #19's last Quarterly MDS assessment was completed on 2/6/19. There were no other assessments after this date, confirming that the MDS assessment was not completed in a timely manner. r. Resident #20's Annual MDS assessment was completed on 2/6/19. There were no other assessments after this date, confirming that the MDS assessment was not completed in a timely manner.	F 638	D. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance will be put in place? The DON will report findings to the Jaquith Inn's NHA weekly. The NHA will report to the JNH monthly Executive Committee Meeting and the Quarterly Jaquith Inn 's Quality Assurance Performance Improvement (QAPI) Committee meeting the progress and effectiveness of the corrected actions. Should systemic changes not be effective, QAPI will investigate and determine further action(s) to be implemented. The corrective action was completed on July 24, 2019.	

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F 638	Continued From page 4 s. Resident #21's Annual MDS assessment was completed on 2/6/19. There were no other assessments after this date, confirming that the MDS assessment was not completed in a timely manner. An interview was conducted with the MDS Coordinator on 6/19/19, at approximately 9:30 AM. The Coordinator confirmed that 19 of 19 residents, identified by MDS data, did not have timely quarterly assessments completed.	F 638		
F 814 SS=F	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure that waste was properly contained in dumpsters or compactors and failed to ensure a garbage storage area was maintained to prevent the harboring of pests. Findings include: A tour of Building #56's kitchen area was conducted along with the Registered Dietician (RD) on 6/17/19 at approximately 9:45 AM. An observation of the garbage disposal unit revealed that a garbage chute led down into a dumpster/compactor. Observation of the unit revealed that the door to the chute was open. At the bottom of the chute, several garbage/waste items including food, debris, milk cartons, and butter packets were observed on the edge of the dumpster/compactor as well as on the ground. There was water pooled inside the compactor	F 814	A. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? On the afternoon of June 20, 2019, all debris was removed from the area around the dumpster/compactor by the Contracted Food Service Company's staff and the dumpster/compactor was emptied and replaced by the Contracted Waste Management Company. Every other Thursday, the dumpster/compactor is scheduled to be emptied and replaced. Additionally, on June 20, 2019, the Contracted Food Service Company's Production Manager submitted a repair ticket with the Contracted Waste Management Company to position the dumpster correctly and to repair the	7/24/19

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F 814	Continued From page 5 with worm-like insects navigating in the brownish water. Several flies were observed flying in and around the dumpster/compactor area. The RD acknowledged the observation and stated that she would have someone attend to the area. On 6/20/19 at 9:30 AM, an observation of the outside of the dumpster/compactor area at Building #56, revealed garbage items on the ground next to the dumpster/compactor. An observation of the garbage storage area revealed that the door to the chute was open and multiple items were observed on the rim of the exposed dumpster/compactor. Flying insects were observed in and around the dumpster. An interview with the Production Manager was conducted on 6/20/19 at approximately 9:35 AM. An inquiry was made regarding the garbage storage area and whether the area had been cleaned. The Production Manager stated that the problem had not been resolved. An interview was conducted with the Administrator on 6/20/19 at approximately 10:20 AM. The Administrator confirmed that the dietary staff was working on the issues with the dumpster/compactor but had not gotten them resolved.	F 814	broken chute. On June 21, 2019, a second repair ticket was submitted by the Contracted Food Service Company's Production Manager for the repositioning of the dumpster/compactor and repair of the chute. The dumpster/compactor was repositioned and the chute was welded and repaired by the Compacted Waste Management Company on June 22, 2019. As part of the routine maintenance procedures, the Mississippi State Hospital (MSH) Maintenance Department replaces fly bait every Thursday and sprays/fogs the air every Tuesday and Thursday (as long as the temperature is greater than 69 degrees Fahrenheit) to help limit or control the flies and pest. B. How you will identify other residents having the potential to be affected by the same deficient practice? On June 20, 2019, the Minimum Data Set (MDS) Nurse reviewed the Jaquith Inn' s census and found that 53 of the 57 residents had the potential to be affected, but no other residents were found to be affected. C. What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur? On June 17, 2019, the Contracted Food Service Company's staff posted signs on the screen door leading to the chute and on the door of the chute that stated, "Please keep door closed at all times" in	

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F 814	Continued From page 6	F 814	order to curtail pest accumulation and to serve as a visual aide to keep the chute and screen door secured. The Contracted Food Service Company's staff will inspect and remove any debris located around the dumpster/compactor twice a day or more often as needed. On July 22, 2019, the Contracted Food Service Company's Food Service Director submitted a request to the District Manager of the Contracted Food Service Company to have the inside of the dumpster cleaned monthly. The request was approved on July 23, 2019 by the Contracted Food Service Company's District Manager. Scheduled cleaning services of the dumpster/compactor will begin on August 1, 2019 by the Contracted Waste Management Company and the Contracted Food Service Company's staff will begin monthly cleaning of the chute. Additionally, on July 23, 2019, an in-service was conducted by the Contracted Food Service Company's Food Service Director with emphasis on the importance of closing the dumpster/compactor chute door and the screen door to the dumpster/compactor room after each use. D. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance will be put in place. The Contracted Food Service Company's Food Service Director will provide monthly documentation to the Jaquith Inn's Nursing Home Administrator (NHA) for the	

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F 814	Continued From page 7	F 814	cleaning of the dumpster/compactor, cleaning of the chute, and the placement of the fly bait. This documentation will be maintained in a binder in the NHA's office. The Jaquith Inn's NHA or the Coordinator of Unit of Operations (CUO) along with the Contracted Food Service Company's Food Service Director will make monthly rounds to ensure the dumpster/compactor and chute is clean and free of debris and pest. Any deficiencies will be documented and reported to the Contracted Food Service Company's Food Service Director for immediate action. The Jaquith Inn's NHA will report to the Jaquith Nursing Home (JNH) monthly Executive Committee Meeting and the Quarterly Jaquith Inn's Quality Assurance Performance Improvement (QAPI) meeting 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 corrective actions were completed on July 24, 2019.	

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	25A197	A. BUILDING **01 - BUILLDING 78** B. WING _____	**06/18/2019**

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000		

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

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E 000	*Initial Comments* * EMERGENCY PREPAREDNESS * Survey conducted on 6/18/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were identified.	E 000		

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