STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A403	A. BUILDING _____ B. WING _____	05/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JNH-ADAMS INN	3550 HIGHWAY 468 WEST PO BOX 207, BUILDING 31 & 48 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 *Based on Administrative review, the CMS 2567 was amended on 6/17/2015 with changes made to scope and severity.* The State Agency (SA) conducted an annual recertification survey at the facility 5/13/15 to 5/15/15. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation, and cited regulatory deficiencies at F160, F280, and F441. The census at the time of the survey was 80. The facility was certified for 86 beds.	F 000		
F 160 SS=D	483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to disperse Residents' Trust Funds after discharge for 3 (three) of 16 total charts reviewed, for Residents #11, #12, and #13. Findings include: Resident #11	F 160	**a. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The deficient practice could not be correct for resident #11. On 5/18/15, residents' #12 and #13 funds were dispersed from their Resident Trust Fund accounts. **b. How you will identify other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken.** Adams Inn Social Worker checked the Resident Trust fund account for resident that were discharged or deceased between 12/01/14 and 06/01/15. No other residents were found to be deficient.	07/10/15

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

Dawn Sanders — Adm — 6/25/15

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.

Dawn Sanders — Adm — 6/30/15

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F 160	Continued From page 1 Review of the facility's policy entitled, "Resident Fund Accounts" dated 05/13, revealed Procedure: 0. "Upon immediate notification to the Cashier's Office, the name of all discharged residents will be recorded in a log. Within five (5) working days of this notification, patient's accounting records will be reviewed to determine the amount of any unpaid obligations of the resident. Once these obligations have been settled, action will be taken to clear the account. These procedures will be executed within 30 days from the date of discharge". Review of Resident #11's closed record revealed the Resident expired in the facility on 10/14/14. Review of the Resident's Trust Fund account revealed the $27.00 balance in the account was not dispersed until12/02/14. Interview on, 05/14/15 at 3:40PM, with the Physical Services Director, and the Finance Director verified Resident #11's Trust Fund account was dispersed on 12/02/14. The Directors stated, Resident Trust Funds are usually dispersed within 30 days, and the Director of the Cashiers usually oversees the process. The Directors reported the Director of Cashiers had resigned, and the facility had not found a replacement for him/her yet. Review of the Identification and Summary Sheet revealed the facility admitted Resident #11 on 09/18/13 with the included diagnosis of Schizophrenia.	F 160	Beginning 6/9/15 Adams Social Worker will use Adams Inn's Resident Trust Fund Disperse After Decease or Discharge Checklist to ensure that all deceased or discharged residents' funds are dispersed within 30 days **c. What measures will be put into place, or what systemic changes you will put into place or make to ensure that the deficient practice does not recur.** On 06/05/15, Adams Inn's Nursing Home Administrator (NHA) in-serviced the Adams Inn Social Worker on policy POL 141-02, Jaquith Nursing Home Resident Fund Accounts. Beginning 05/18/15, the Mississippi State Hospital (MSH) Director of Financial Services in-serviced the MSH Cashiers on policy POL 141-02. This in-service was completed on 06/18/15 due to newly hired cashiers. Beginning 06/09/15, upon the death or discharge of a resident with a personal fund deposit with the facility, Adams Inn's Social Worker will submit the resident's information to the MSH Cashier's office the next working day following the death or discharge. The Adams Inn's Social Worker will check with MSH's Cashier's office every 10 days for 30 days to ensure the resident's	

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F 160	Continued From page 2 Resident #12 Review of Resident #12's closed record revealed the Resident expired in the facility on 03/09/15. Review of the Resident's Trust Fund account revealed the balance of ($6,396.57) remained in the account. An interview, on 05/14/15 at 3:40PM, with the Physical Services Director, and the Finance Director revealed Resident #12's Trust Fund account balance was $6,396.57. The Directors stated, Resident #12 should have had the room and board deducted from the trust fund account, and the remaining balance on the account should have been $44.00. Review of the Identification and Summary Sheet revealed the facility admitted Resident #12 on 11/20/14 with diagnoses, which included Cognitive Disorder. Resident #13 Review of Resident #13's closed record revealed the Resident was discharged from the facility on 03/27/15. Review of the Resident's Trust Fund account, revealed the balance of($44.06) remained in the account. An interview, on 05/14/15 at 3:40PM, with the Physical Services Director, and the Finance Director validated the balance of the account had not been dispersed. Review of the Identification and Summary Sheet revealed the facility admitted Resident #13 on	F 160	**c. (continued)** funds are dispersed to the individual or the probate jurisdiction administering resident's estate according to policy. Jaquith Nursing Home's Social Services Director will review each Adams Inn's death or discharge occurrence with Adams Inn Social Worker on the 25 day after the resident is deceased or discharged from the facility. **d. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place.** Beginning 06/09/15, Jaquith Nursing Home's Social Services Director will review each Adams Inn's death or discharge resident's funds accounts within 25 day after the resident leaves the facility to ensure the funds are disperse according to policy. The JNH Social Services Director will inform the Adams Inn's NHA of any deficiencies. Adams Inn's NHA will report any deficiencies to JNH's Executive Committee for further corrective actions if necessary.	

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F 160	Continued From page 3 08/07/14 with diagnoses, which included Schizophrenia.	F 160		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and facility policy review, the facility failed to revise the care plan as the resident's condition changed with the potential for inadequate care for 1 (one) of 16 records reviewed [Resident #2]. Findings include: Review of the facility's policy entitled, " Nursing	F 280	**a. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** On 05/18/15, Resident #2's care plan was reviewed and updated to reflect behavior of sitting on the floor; history of false accusations; risk for falls and an approach to keeping the call light within reach while in bed; risk for pressure areas not including preventive skin care measures for residents heels; mechanical altered diet to include Speech Therapy services to be provided 5x(times weekly x 1 week to determine least restrictive diet, develop compensatory strategies and provide staff education ; and wander risk. **b. How you will identify other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken.** On 05/18/15, the Adams Inn DON and Adams Inn Minimum Data Set (MDS) RN reviewed and updated all of the care plans for residents of Adams Inn. Beginning 5/22/15, the Adams Inn MDS RN will utilize the Adams Inn Care Plan Worksheet	07/10/15

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F 280	Continued From page 4 Documentation" (dated December 2014) revealed, "It is the professional responsibility of all licensed nurses to provide an accurate, in-depth clinical record of care for assigned residents. (Name of Nursing Home) documentation criteria are as follows: Care Plans: (1) Are initiated on admission. (2) Updated upon re-admission. (3) Whenever resident care changes (physical status)." Review of Resident #2's care plans revealed the following Problems/Needs and Approaches: 1. Behavior of sitting on the floor (2/19/13) with a review date 5/13/2015. 2. History of false accusations (3/1/12) with a review date 2/19/15. 3. Risk for falls 12/13/08 with a review date 2/19/15, and an approach to keep the call light within reach while in the bed. Teaching on usage with return demonstration. 4. Risk for Pressure Areas (12/13/08) with a review date 2/19/15, and did not include approaches for preventive skin care measures for the resident's heels. 5. Mechanical Altered Diet (10/6/10) with a review date 2/19/15- did not include an approach on diet care plan to include a new physician's order 5/11/15 for "ST (Speech Therapy) services to be provided 5x(times) wkly (weekly) X 1 week to determine least restrictive diet, develop compensatory strategies and provide staff education". 6. Wander Risk (8/1/13) with a review date 2/19/15. An interview on, 5/15/2015 at 11:00AM, with	F 280	to ensure that all care-plans are updated. The MDS RN will update each care-plan ***as resident's condition changes***. The updated care plan will then be taken to the Adams Inn Treatment Team for discussion by the Treatment Team Members. **c. What measures will be put into place, or what systemic changes you will put into place or make to ensure that the deficient practice does not recur.** On 5/15/15, the Adams Inn Director of Nurses (DON) began in-servicing all Adams Inn's Registered Nurses (RN) and Licensed Practical Nurses (LPN) on policy #J550-47 Nursing Documentation, Policy #J550-47 ATT A Suggested Documentation Guide and Policy # J500-25 Treatment Team. In-servicing was completed on 6/1/15. The Adams Inn's (DON) in-serviced the Adams Inn's Minimum Data Set (MDS) RN on 5/18/15 on care plan initiation and updates upon admission, quarterly, annually and with significant changes of Adams Inn residents. All newly hired nursing staff will be in-serviced on Policy #J550-47 ATT A Suggested Documentation Guide and Policy # J500-25 Treatment Team prior to working on Adams Inn.	

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F 280	Continued From page 5 Registered Nurse (RN) #1 revealed Resident #2 had a recent diet change to a soft diet due to problems with chopped meats. RN #1 also reported Resident #2 received preventive skin care to her heels. An interview on, 5/15/2015 at 12:50PM, with RN #3/Minimum Data Set (MDS) Nurse revealed the care plans are updated quarterly, and as needed. RN #3/MDS Nurse stated when the nurses note a new order, they should update the care plan at that time. RN #3/MDS Nurse stated she asks the nurses about any changes, refers to the 24 Hour Report, and asks the floor nurses about any changes in the resident's care. RN #3/MDS Nurse said," I should have resolved some of those (Resident #2's) problems." Resident #2 was "no longer a wander risk, not ambulatory." She stated that Resident #2 had not falsely accused anyone in a while, and some of the other listed behaviors were resolved including sitting on the floor. An interview on, 5/15/2015 at 1:OOPM, with Certified Nursing Assistant (CNA) #2 revealed Resident #2 cannot ambulate unassisted, and was unable to ambulate any lengthy distance. An interview on, 5/15/2015 at 1:20PM, with RN #2 revealed Resident #2 was not a wander risk, and did not understand the use of a call light. Review of the facility's Face Sheet revealed the facility admitted Resident #2 on 9/9/2005. Resident #2's diagnoses included Schizoaffective Disorder and Mental Retardation by history. Review of the MDS with an Assessment Reference Date (ARD) of 02/17/2015 revealed Resident #2 had a Brief Interview of Mental Status (SIMS) score of zero-zero (00) wt)ich indicated severe cognitive impairment. Further review of the MDS revealed no concerns with	F 280	**c. (continued)** Beginning 5/22/15, the Adams Inn MDS RN will submit the Adams Inn Care Plan Worksheet to the Adams Inn DON every Friday. The Adams Inn DON will review the Care plan worksheet every Monday to ensure the updated care plans are on the resident's chart. In the Absence of the Adams Inn Director of Nurses, the Adams Inn Charge Nurse will review the care plan to ensure it has been updated. **d. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place.** Beginning 5/22/15, the Adams Inn's DON will ***review*** the Adams Inn Care-Plan Worksheets ***every Monday and check*** to ensure that care plans are updated. Any noted deficiencies will be immediately corrected and reported to the Adams Inn's Nursing Home Administrator (NHA). The Adams Inn NHA will report any noted deficiencies to the Jaquith Nursing Home Executive Committee for further corrective actions if necessary.	

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F 280	Continued From page 6 behaviors, totally dependent, and required one (1) person assistance with locomotion on and off the unit, limited assistance with one (1) person for transfers, and walking in the room/corridor did not occur.	F 280		
F 441 SS=E	483.651NFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441	**a. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** On 05/15/15, the three combs, three opened containers of body powder, one container of roll on deodorant, two cans of spray deodorant and one open container of hand and body lotion that were un-bagged and unlabeled were removed and discarded from the Female Shower Room. On 5/15/15, the three cans of spray deodorant with lids missing and one can shaving cream that were un-bagged and unlabeled were removed and discarded from the supply cart on the Female hall. **b. How you will identify other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken.** All residents of Adams Inn who are not provided a safe, clean, comfortable, home like environment have the potential to be affected by this deficient practice.	07/10/15

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F 441	Continued From page 7 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review, the Facility failed to label14 personal hygiene items located in one of three (1 of 3) resident shower rooms, and one of three (1 of 3) supply carts. Findings Include: Review of the facility's policy entitled," PATIENT PERSONAL HYGIENE CONTAINER" (dated August 2013,) revealed that all patients have appropriate items for maintaining personal hygiene. Each patient will receive a container that contains the following items: toothbrush, toothbrush holder, roll-on deodorant, cornstarch powder, lotion, non-alcoholic mouthwash, and a comb, to promote infection control and good hygiene. These supplies will only be used by the patient who receives them. The container will be tagged with the patient's name and, although the container itself may be reused by the hospital, the items in the container become the personal property of the patient. Observations during the environmental rounds with the Coordinator of Unit Operations (CUO) of Building# 31's Female Shower Room on, 05/15/15 at 12:15 PM, revealed the following unlabeled, and un-bagged items: 1.) Three (3) combs. 2.) Three (3)opened containers of body	F 441	Beginning 5/15/15, The Adams Inn Direct Care Alternate Supervisor (DCAS) will use the Adams Inn Shower and Supply Cart Check Sheet to inspect the shower room and supply carts daily and on weekends after all ADL care has been provided to ensure all unlabeled, un-bagged, and personal hygiene items are stored ***in resident's nightstand*** according to policy. **c. What measures will be put into place, or what systemic changes you will put into place or make to ensure that the deficient practice does not recur.** On 05/15/15, the Adams Inn Director of Nurses began in-servicing all Adams Inn Registered Nurses (RN's), Licensed Practical Nurses (LPN's), Certified Nursing Assistants (CNA's), Pantry, Housekeeping, Recreation, Social Worker, Psychology, Laundry, Medical Records Clerk and Coordinator of Unit Operations (CUO) on Policy #210-72, "Patient Personal Hygiene Container". The In-services were completed on 06/01/15. All newly hired Adams Inn staff will be in-serviced on Policy #210-72 prior to working on Adams Inn.	

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F 441	Continued From page 8 powder. 3.) One (1) container of roll on deodorant. 4.) Two (2) cans of spray deodorant. 5.) One (1) opened container of hand and body lotion. Observations during the environmental rounds with the CUO on, 05/15/15 at 12:15 PM, revealed the following un-labeled, and un-bagged items on a supply cart on the Female Hall: 1.) Three(3) cans of spray deodorant with the lids missing from two of the cans, and 2.) One (1) opened can of shaving cream. During an interview on, 05/15/15 at 12:25 PM, the CUO (Coordinator of Unit Operations) verified the unlabeled items. She stated that it was a nursing problem. When asked about these items being an infection control issue, He/ she said that they personally did not know much about nursing things. During an interview on, 05/15/15 at 12:45 PM, CNA (Certified Nursing Assistant)#1 revealed each resident was issued two (2) personal hygiene bags that were kept in the resident rooms, or stored in a central storage area. One bag was for toileting needs (diapers, wipes), and the other for bathing (soap, shaving cream, deodorant). Each bag was to be labeled. During an interview on, 05/15/15 at 1:05 PM, the DON (Director of Nursing) stated all personal hygiene Items should be stored In a labeled bag issued to each resident. The DON did not provide	F 441	**c. (continued)** Beginning 5/18/15, the Adams Inn's medication Licensed Practical Nurse (LPN) will inspect the shower/bath rooms and supply carts on Mondays and Thursdays each week after ADL care and before shift change to ensure that the Adams Inn Shower and Supply Cart Check Sheet is completed. All unlabeled, un-bagged, and personal hygiene items will be disposed of. **d. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place.** Beginning 05/18/15, the Adams Inn DON will check the Adams Inn Shower and Supply Cart Check Sheet weekly to ensure that there are no noted deficiencies. The Adams Inn DON will report any deficiencies to the Adams Inn's Nursing Home Administrator (NHA). . The Adams Inn NHA will report any noted deficiencies to the Jaquith Nursing Home Executive.	

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F 441	Continued From page 9 an explanation why the residenfs personal hygiene items were not in the labeled bags.	F 441		

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	25A403	A. BUILDING **48 - BUILDING 48** B. WING _____	**05/19/2015**

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility meets the applicable provisions of the 2000 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000		

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

David Sanders | NHA | 6/25/15

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.

David Sanders | NHA | 6/30/15