STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A402	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jnh-Jefferson Inn	3550 Hwy 468 West Whitfield, MS 39193

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 48669 Based on interviews and record review, the facility failed to ensure a Certified Nurse Aide (CNA) followed the resident's care plan, which resulted in an unwitnessed fall from the bed for one (1) of three (3) the residents reviewed for accidents. Resident #1 Findings include: Record review of Care Plan, with a problem onset date of 5/10/2023 revealed : Requires the use of Siderails x 2 in bed r/t (related to) Profound IDD (Intellectual and Developmental Disability), Delusional Disorder, and Unaware of Safety Hazards .Approaches .Siderails up x 2 when in bed . On 3/20/24 at 11:02 AM, in an interview with the Administrator, she revealed CNA #1 did not follow Resident #1's care plan. The Administrator confirmed that she expects all staff to adhere to physician orders and to follow the resident's care plan, as the care plan is a guideline for how staff are to care for the residents and not following it puts the resident at harm. On 3/20/24 11:27 AM, in an interview with the Director of Nursing (DON), she revealed she has educated the CNA's on following the plan of care for resident care. She stated the ADL (Activities of Daily Living) guidebook, which is an extension of the care plan is specific to each resident's needs and is for CNAs to use while caring for their residents. She confirmed the siderail requirements, for Resident #1, were reflected in the guidebook, but CNA #1 did not follow the guidelines for the care of Resident #1. On 3/20/24 at 1:38 PM during the interview with CNA#1, she confirmed she uses the ADL guidebook to care for her residents and acknowledges the bedrail requirement for Resident #1 was in the guidebook. CNA #1 stated the night Resident #1 fell , she had decided to let the siderails down to prevent the resident from becoming agitated. On 3/20/24 at 2:13 PM, during a phone interview with Licensed Practical Nurse (LPN) #1, confirmed that she knows they must always follow the care plan. She said she assessed Resident #1 after the fall as per protocol, which included such as vital signs and neuro checks. During her assessment she stated she noticed the siderails were down. A record review of the Identification and Summary Sheet revealed Resident #1 was admitted by the facility on 4/27/23. Her diagnoses included Delusional Disorder, Atrial Fibrillation and Hypertension.

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A402	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2024
NAME OF PROVIDER OR SUPPLIER Jnh-Jefferson Inn		STREET ADDRESS, CITY, STATE, ZIP CODE 3550 Hwy 468 West Whitfield, MS 39193	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 48669 Based on interviews, record review, facility investigation, and facility policy review, the facility failed to ensure a dependent resident was supervised and physician ordered assistive devices were implemented to prevent an unwitnessed fall from bed for one (1) of three (3) the residents reviewed for accidents. Resident #1 Findings include: Record review of the facility's policy titled, Standards of Care, dated May 2022, revealed, 1. PURPOSE AND APPLICABILITY This policy identifies the designated nursing reference manual for licensed and unlicensed nursing staff . in all programs . 2. POLICY: .The certified nursing assistant textbook currently in use by Staff Education is the designated reference manual for unlicensed nursing staff 3. PROCEDURE . D. Prior to executing any clinical procedure, all nursing staff will: (1) Verify physician/nurse practitioner order for patient/resident . Record review of the Investigative Findings, dated March 8, 2024, revealed the investigation of a fall involving Resident #1. The initial concern identified in the investigation was that the fall of Resident #1 may have been related to the resident's unexpected death, due to the close proximity of the two (2) events. However, through the facility's investigation, the facility determined that the death of Resident #1 was unrelated to the fall. Further review of the facility's investigation revealed that on February 23, 2024, the Certified Nurse Aide (CNA) assigned to her care, failed to follow the physician's orders related to the use of siderails when the resident was in bed. Record review of RCA (Root Cause Analysis) Review dated February 26,2024 revealed .Concerns .2. There was a physician's order for the bed's side rails to be up, but they were not .Root Causes A. Fall The root cause for the resident's fall was the side rails of the bed were not raised in accordance with the physician's order . Record review of a handwritten Physicians Orders dated 2/9/24 revealed Siderails x 2 when in bed R/T (related to) Profound IDD (Intellectual and Developmental Disability), Delusional Disorder, Does not foresee potential hazards x 30 days . On 3/20/24 at 11:02 AM, in an interview with the Administrator she revealed that during their morning meeting, it was discovered that the CNA #1 put the siderails down while Resident #1 was in bed, which could have led to the fall of Resident #1. The Administrator revealed CNA #1 did not follow the physician orders and plan of care regarding the care of Resident #1. The Administrator stated she expects all staff to adhere to the physician orders. On 3/20/24 at 11:27 AM, in an interview with the Director of Nursing (DON), she revealed she has educated the CNA's on following the plan of care for residents. She stated the ADL (Activities of Daily Living) guidebook is specific to each resident's needs. The DON confirmed the CNAs are to use the guidebook, while caring for their residents. She confirmed that the siderail requirements for Resident #1 were reflected in the guidebook, however, CNA #1 did not follow the guidebook. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/20/24 at 1:38 PM during the interview with CNA#1, she confirmed she has been caring for Resident #1 since she was admitted a year ago by the facility as well as the night the resident fell out of bed. She indicated she uses the ADL guidebook to care for her residents and acknowledges the bedrail requirement for Resident #1 was in the guidebook. However, she explains that the resident was the type of resident who would do whatever she wanted, regardless of trying to redirect her. The CNA stated that when the siderails were up, the resident would kick, hit, or spit or just try to climb over the rails altogether. So, the night she fell , the CNA had decided to let them down to prevent the resident from becoming agitated. CNA# 1 revealed she had not notified the nurse on duty about the resident's behaviors or that she had let the siderails down for Resident#1. On 3/20/24 at 2:13 PM, during a phone interview with Licensed Practical Nurse (LPN) #1, she confirmed she was working the night Resident #1 fell . She revealed CNA #1 had reported to her that she had found the resident sitting up on the floor with the sheets around her feet. She said she assessed the resident as per protocol, which included such as vital signs and neuro checks. During this time, she noticed the siderails were down but when questioning the CNA #1, she never got a clear answer about how the siderails got down. LPN#1 admits that she knows they must always follow the physician orders and that nurses must contact the physician before making any changes to the resident's care. A record review of the Identification and Summary Sheet, revealed the facility admitted Resident #1 on 4/27/23. Her diagnoses included Delusional Disorder, Atrial Fibrillation, and Hypertension. A record review of the Minimum Date Set (MDS), for Resident #1, with an Assessment Reference Date (ARD) of 1/25/24, revealed a Brief Interview for Mental Status (BIMS) score of 00, which indicated the resident had severe cognitive impairment.