Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A402	A. Building B. Wing	08/08/2024

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41680 Based on observations, interviews, and record reviews the facility failed to follow physician orders for dietary supplements for one (1) of two (2) residents reviewed for nutrition. Resident #68 Findings Include: On 08/05/24 at 1:25 PM, an observation of Resident #68 eating lunch in the dining room revealed the resident could feed himself, using his left hand, after staff set up his tray. The resident consumed 100% of his meal, but there was no dietary supplement on his lunch tray. On 08/06/24 at 1:20 PM, an observation of Resident #68 eating lunch in the dining room revealed that Certified Nursing Assistant (CNA) #1 noted that there was no Boost on his tray, so she left the dining area and returned with the Boost in hand. The resident immediately picked it up and began to consume it. On 08/07/24 at 10:10 AM, in an interview with the Registered Dietitian (RD), she stated she expected the staff to honor residents' preferences and encourage them to eat. She mentioned she expected the staff to offer the Boost and noted the resident had gained some weight over the past couple of months. On 08/07/24 at 1:00 PM, an observation of Resident #68 eating in the dining room revealed Boost was not on the lunch tray. On 08/07/24 at 3:25 PM, in an interview, CNA #1 stated when a resident has an order for a supplement, it is usually placed on the resident's meal tray. On 08/07/24 at 4:15 PM, during an interview, the Director of Nursing (DON) stated when there is a nutritional change, the order form goes to the pantry so they will be informed of the changes. She stated the Registered Dietitian (RD), pantry person, nurse, and CNAs are all informed about it. She confirmed it was the nurse's responsibility to give the resident a supplement as ordered by the physician and to make sure that it is charted accurately. On 08/08/24 at 10:15 AM, during an interview, the RD stated she reviewed Resident #68's chart and had recently changed the order to double portion meals and Boost four (4) times a day (QID). She confirmed the resident should receive Boost four (4) times a day. (continued on next page)

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

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/08/24 at 10:32 AM, in an interview, CNA #2 stated she did not have access to get the supplement from the medication room. She stated Resident #68 was supposed to get Boost with every meal and emphasized it was the nurse's responsibility to give the resident his Boost. She noted she had observed it not being on the tray at times, but when she was there, she would ask the nurse for the Boost. A record review of Resident #68's Identification and Summary Sheet revealed an admitted [DATE] with diagnoses of Huntington's Disease, Depression, and Gastric Esophageal Reflux Disease. A record review of Resident #68's Physician Orders, dated 6/26/24 revealed an order for pureed diet x 2 (double portions) with Boost QID (four times a day) and when requested.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 47873 Based on observations, staff interviews record review and facility policy review, the facility failed to date medications that were opened and stored in two (2) of four (4) medication refrigerators in medication storage rooms. Findings Include: A record review of the facility policy titled MultiDose Vials, dated 11/21, revealed 1.This policy establishes the requirements to regulate the use of multidose vials to ensure stability and prevent contamination . 2. POLICY: The pharmacy attempts to supply injectable drugs in unit of use vials when practical, but many items are only available in multidose vials. 3. PROCEDURE: A. All multi-dose vials must be dated with a 28-day expiration date from the time of initial puncture . On 08/07/24 at 08:30 AM, during an observation of the medication room in Building 33 on the second floor with Licensed Practical Nurse (LPN) #1, the medication refrigerators were found to contain Novolin R vials that had been opened and not dated. On 08/07/24 at 08:35 AM, an interview with LPN #1 revealed that nurses were trained during orientation and at least yearly on medication labeling and storage, especially insulin. It was the responsibility of the nurse who opened the vial to date it. On 08/07/24 at 08:45 AM, during an observation of the medication room in Building 33 on the first floor with Registered Nurse (RN) #2, the medication refrigerators were found to contain vials of Novolin R and Levemir that had been opened and not dated. On 08/07/24 at 08:50 AM, an interview with RN #2 revealed it was the responsibility of the nurse to date the vial when it was opened. On 08/07/24 at 11:19 AM, an interview with the Director of Nursing (DON) of the facility, confirmed that nurses have received training regarding the importance of dating multidose vials when they are opened. The DON stated the nurses are to follow facility policy and date the vials as they are opened.