STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A178	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JASPER COUNTY NH	**15 A SOUTH SIXTH STREET PO BOX 527, BAY SPRINGS, Mississippi, 39422**

(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
F0000	INITIAL COMMENTS The State Agency (SA) conducted a Facility Reportable Complaint Investigation (CI MS #3056477), at the facility on 7/8/26. CI MS #3056477was investigated related to falsification of records, quality of care/Treatment, nursing services, and Neglect. During the survey, the SA determined the facility was in compliance with the requirements for participation in Medicare and Medicaid and cited F 0658 and F 0842. Based on the facility's implementation of corrective actions on 7/2/26, the SA determined the deficiencies to be Past Non-Compliance (PNC), prior to the SA's entrance on 7/8/26. The facility held a license for 110 beds, with a census of 103.	F0000		
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interviews, and facility policy review, the facility failed to administer physician-ordered medications and treatments in accordance with professional standards of practice by failing to administer a physician-ordered oral diabetic medication and perform physician-ordered blood glucose monitoring as prescribed for one (1) of three (3) residents reviewed for medication administration. (Resident #1). Findings include: A review of the facility's policy titled, "JCNH (Jasper County Nursing Home) Medication Administration Policy," revised 7/30/25, revealed "Policy: Medications are administered… as ordered by the	F0658	"Past Noncompliance - no plan of correction required"	

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 reverse for further 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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F0658 SS = D	Continued from page 1 physician and in accordance with professional standards of practice…" A review of the facility investigation revealed the facility became aware of the concern on 6/23/26 after Resident #1's daughter reported the resident had not received her scheduled Metformin or blood glucose monitoring. The investigation included review of video surveillance, which confirmed Licensed Practica Nurse (LPN) #1 did not enter Resident #1's room during the scheduled medication pass on 06/22/2026 or 06/23/2026. LPN #1 admitted she did not administer the ordered Metformin or obtain the physician-ordered blood glucose readings on either date despite documenting both as completed in the Medication Administration Record (MAR). The investigation resulted in termination of LPN #1 for falsification of medical records. A record review of the Medication Administration Record (MAR) revealed documentation indicating blood glucose monitoring was completed at 11:00 AM and Metformin 500 mg was administered at 12:00 PM on 06/22/2026 and 06/23/2026. Both entries were electronically signed by LPN #1. On 7/8/26 at 9:30 AM, during an interview with the Administrator confirmed, the facility became aware of the concern on 6/23/26 after Resident #1's daughter reported the resident had not received her scheduled 12:00 PM Metformin on 6/22/26 and 6/23/26 and that her blood glucose had not been checked. The Administrator confirmed video surveillance showed LPN #1 did not enter the resident's room during the scheduled medication pass on either date. He revealed LPN #1 admitted she did not administer the resident's Metformin or obtain the ordered blood glucose readings on both days, despite documenting the services as completed. The Administrator confirmed the nurse was terminated, the incident was reported to the State Agency, Attorney General's Office, and Mississippi Board of Nursing, and the facility completed staff education and initiated ongoing medication administration audits. On 07/08/2026 at 11:35 AM, during an interview, LPN #1 acknowledged the documentation was inaccurate and confirmed Resident #1 did not receive the ordered medication (Metformin) or blood glucose monitoring as documented on 6/22/26 and 6/23/26. On 07/08/2026 at 11:50 AM, during an interview with the Director of Nursing (DON), she confirmed Resident #1 had physician's orders for daily	F0658		

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F0658 SS = D	Continued from page 2 Metformin and blood glucose monitoring with sliding scale insulin before meals and at bedtime. The DON stated licensed nurses are expected to obtain blood glucose readings and administer medications in accordance with physician orders prior to documenting administration. She confirmed the investigation determined that LPN #1 did not enter the resident's room during the scheduled medication pass, did not obtain the resident's blood glucose, did not administer the ordered Metformin, and falsely documented the services as completed, on 6/22/26 and 6/23/26. The DON acknowledged this practice was not consistent with facility policy or accepted standards of nursing practice. On 07/08/2026 at 12:48 PM, during an interview, Resident #1's daughter stated that on 06/23/2026 she observed LPN #1 did not enter the resident's room to perform the physician-ordered blood glucose monitoring or administer the scheduled noon dose of Metformin. She stated she reported her concerns to the Unit Supervisor, which initiated the facility's investigation. On 07/08/2026 at 1:48 PM, during an interview, the Nurse Practitioner stated she was notified by the facility after the incident was identified. She confirmed LPN #1 had not notified her that Resident #1's physician-ordered Metformin or blood glucose monitoring had not been completed on 06/22/2026 and 06/23/2026. She further confirmed she was not notified the resident refused the medication, was unavailable, or that the physician's orders could not be carried out. A record review of the "Admission Record" revealed Resident #1 was admitted to the facility on 12/29/2025 with diagnoses including Chronic Diastolic (Congestive) Heart Failure and Unspecified Dementia, Mild, without Behavioral Disturbance. A review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/13/26 revealed a Brief Interview for Mental Status (BIMS) score of 08, which indicated moderate cognitive impairment. A record review of Resident #1's "Order Summary Report" revealed active physician orders for "Metformin HCL (hydrochloride) Oral Tablet 500 MG (milligram), Give (1) tablet by mouth one time a day, dated 6/15/26," and "Novolog Injection Solution 100 Unit/ML (milliliter) (Insulin Aspart) Inject as per sliding scale…before meals and at bedtime…dated 12/30/25".	F0658		

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F0658 SS = D	Continued from page 3 Validation: The SA validated on 7/8/26, through interview and record review that all corrective actions had been implemented as of 7/2/26, and the facility was in compliance as of 7/2/26, prior to the SA's entrance on 7/8/26.	F0658		
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse,	F0842	"Past Noncompliance - no plan of correction required"	

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F0842 SS = D	Continued from page 4 neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to maintain complete and accurate clinical records by documenting physician-ordered medication administration and blood glucose monitoring as completed when the ordered services were not provided, for one (1) of three (3) residents reviewed for clinical record accuracy. (Resident #1) Findings include:	F0842		

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F0842 SS = D	Continued from page 5 A review of the facility investigation revealed the facility became aware of the concern on 6/23/26 after Resident #1's daughter reported the resident had not received her scheduled Metformin or blood glucose monitoring. The investigation included review of video surveillance, which confirmed Licensed Practical Nurse (LPN) #1 did not enter Resident #1's room during the scheduled medication pass on 06/22/2026 or 06/23/2026. LPN #1 admitted she did not administer the ordered Metformin or obtain the physician-ordered blood glucose readings on either date despite documenting both as completed in the Medication Administration Record (MAR). The investigation resulted in termination of LPN #1 for falsification of medical records. During an interview on 07/08/2026 at 9:30 AM, the Administrator, confirmed the facility became aware of the concern on 6/23/26 after Resident #1's daughter reported the resident had not received her scheduled 12:00 PM Metformin on 6/22/26 and 6/23/26 and that her blood glucose had not been checked. The Administrator confirmed video surveillance showed LPN #1 did not enter the resident's room during the scheduled medication pass on either date. He revealed LPN #1 acknowledged she did not administer the resident's Metformin or obtain the ordered blood glucose readings on both days, despite documenting the services as completed. The Administrator confirmed the nurse was terminated, the incident was reported to the State Agency, Attorney General's Office, and Mississippi Board of Nursing, and the facility completed staff education and initiated ongoing medication administration audits. During an interview on 07/08/2026 at 10:55 AM, LPN #2 stated a Registered Nurse (RN) informed her that Resident #1's daughter reported no staff had entered the resident's room to perform the physician-ordered blood glucose monitoring on 06/23/2026. LPN #2 stated she immediately notified the Director of Nursing (DON), and together they reviewed the facility's video surveillance. She confirmed the surveillance showed no nursing staff entered Resident #1's room between 10:00 AM and 1:00 PM on 06/22/2026 or 06/23/2026. LPN #2 stated LPN #1 initially reported she had entered the room, administered the resident's Metformin, and performed the blood glucose check. However, on 06/24/2026, LPN #1 admitted she had not administered the physician-ordered Metformin or performed the physician-ordered blood glucose monitoring (Accu-Chek) on either 06/22/2026 or 06/23/2026. LPN #2 confirmed the resident's physician was notified.	F0842		

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F0842 SS = D	Continued from page 6 During an interview on 07/08/2026 at 11:35 AM, LPN #1 acknowledged the documentation was inaccurate and confirmed Resident #1 did not receive the ordered medication (Metformin) or blood glucose monitoring as documented on 6/22/26 and 6/23/26. During an interview on 7/8/26 at 11:50 AM, with the Director of Nursing (DON), she confirmed Resident #1 had physician's orders for daily Metformin and blood glucose monitoring with sliding scale insulin before meals and at bedtime. The DON stated licensed nurses are expected to obtain blood glucose readings and administer medications in accordance with physician orders prior to documenting administration. She confirmed the investigation determined that LPN #1 did not enter the resident's room during the scheduled medication pass, did not obtain the resident's blood glucose, did not administer the ordered Metformin, and documented in the MAR that both services had been completed. The DON acknowledged the documentation was inaccurate and not consistent with facility policy or accepted standards of nursing practice. A record review of the "Admission Record" revealed Resident #1 was admitted to the facility on 12/29/2025 with diagnoses including Chronic Diastolic (Congestive) Heart Failure and Unspecified Dementia, Mild, without Behavioral Disturbance. A review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/13/26 revealed a Brief Interview for Mental Status (BIMS) score of 08, which indicated moderate cognitive impairment. A record review of Resident #1's "Order Summary Report" revealed active physician orders for "Metformin HCL (hydrochloride) Oral Tablet 500 MG (milligram), Give (1) tablet by mouth one time a day, dated 6/15/26," and "Novolog Injection Solution 100 Unit/ML (milliliter) (Insulin Aspart) Inject as per sliding scale…before meals and at bedtime…dated 12/30/25". A record review of the MAR revealed documentation indicating blood glucose monitoring was completed at 11:00 AM and Metformin 500 mg was administered at 12:00 PM on 06/22/2026 and 06/23/2026. Both entries were electronically signed by LPN #1. Validation: The SA validated on 7/8/26, through interview and	F0842		

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F0842 SS = D	Continued from page 7 record review that all corrective actions had been implemented as of 7/2/26, and the facility was in compliance as of 7/2/26, prior to the SA's entrance on 7/8/26.	F0842		