Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(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
M0000	Initial Comments The State Agency (SA) conducted a Facility Reportable Complaint Investigation (CI MS #3056477), at the facility on 7/8/26. CI MS #3056477 was 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 Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements and cited M500. 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.	M0000		
M0500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as	M0500	"Past Noncompliance - no plan of correction required"	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(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
M0500	Continued from page 1 referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his	M0500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(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
M0500	Continued from page 2 personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest	M0500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(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
M0500	Continued from page 3 exercise of these rights. This LICENSURE 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 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 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. On 7/8/26 at 9:30 AM, during an interview with the Administrator, he 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	M0500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(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
M0500	Continued from page 4 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 7/8/26 at 11:50 AM, during an interview 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 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)	M0500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(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
M0500	Continued from page 5 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 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.	M0500		