

MSDH - Health Facilities Licensure and Certification

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                          |                                                                                                                          |                          |                                                                    |
|--------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION          |                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>61JE</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>11/30/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>JNH-JEFFERSON INN</b> |                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>3550 HWY 468 WEST</b><br><b>WHITFIELD, MS 39193</b>                          |                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                      | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                    |
| M 000                                                        | Initial Comments<br><br>The State Agency (SA) conducted a Complaint Investigation (CI), MS #23393 at the facility on 11/30/23. MS #23393 was investigated related to Physical Environment for pests. During the survey, the SA determined the facility was in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirement. There were no deficiencies cited. | M 000                                                                    |                                                                                                                          |                          |                                                                    |

Mississippi State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

12/06/23