STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A197	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JNH-JAQUITH INN	3550 HIGHWAY 468 WEST , WHITFIELD, Mississippi, 39193

(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 an annual recertification at the facility from 02/02/26 through 02/05/26. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F636, F761, F812, F851, F880. The facility had a census of 43 and was licensed for43 beds.	F0000		
F0636 SS = D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems.	F0636		

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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F0636 SS = D	Continued from page 1 (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure Minimum Data Set (MDS) assessments were completed and transmitted within required timeframes for two (2) of (2) residents reviewed for death in the facility tracking log. (Resident #10 and Resident #44).	F0636		

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F0636 SS = D	Continued from page 2 Findings include:Record review of the facility policy “Minimum Data Set (MDS) Assessment Policy” (JNH POL J550-43, June 2024) revealed the following highlighted language: " It is the policy of this facility to ensure that the MDS assessment is completed timely, accurately, and in accordance with all applicable Federal and State regulations....The MDS Coordinator is responsible for coordinating, completing, and transmitting all MDS assessments in compliance with CMS requirements...All assessments will be submitted electronically to CMS within the required timeframes...” The policy also specifies that the facility will “ensure accuracy of data prior to submission” and that assessments must reflect the resident’s “current status.” Resident #10 Record review of the clinical record for Resident #10 revealed the resident expired at the facility on 11/26/25 at 07:40 AM. Review of the Minimum Data Set tracking module showed the death in facility assessment had not been transmitted within 14 days of the resident’s death, as required. Record review of Resident # 10's "Patient/Physician Encounter Form" revealed an admission date of 3/4/2011 with diagnoses that included dementia without behavioral disturbance and schizophrenia. A record review of Resident #10’s clinical record (JNH Resident 10.pdf) revealed documentation that the resident expired in the facility on 11/26/25 at 7:40 a.m. The medical record contained physician documentation of death and discharge status indicating death in the facility. Review of the Minimum Data Set (MDS) tracking/assessment history within the record revealed that a Death in Facility assessment had not been completed and transmitted within 14 days of the resident’s date of death. The assessment history did not reflect a transmission date within the required timeframe. Resident #44 Record review of the “Nurse Notes” dated 11/22/25 at 10:10 AM, revealed “(Proper name of physician) pronounced the patient deceased.” Review of the Minimum Data Set tracking module showed the Death in Facility assessment had not been transmitted within 14 days of the resident’s death, as required.	F0636		

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F0636 SS = D	Continued from page 3 A record review of Resident #44's clinical record revealed documentation that the resident expired in the facility on 11/22/25 at 10:10 AM. The medical record included documentation of death and discharge disposition reflecting death in the facility. Review of the MDS tracking/assessment history revealed that a Death in Facility assessment had not been completed and transmitted within 14 days of the resident's date of death. There was no evidence within the assessment history of timely electronic submission within the required timeframe. Record review of the "Patient/Physician Encounter Form" revealed an admission date 8/16/2018 with diagnoses that included major depressive disorder single episode unspecified and type 2 diabetes mellitus. During an interview on 02/04/25 at 2:40 PM, Registered Nurse (RN) # 1 revealed the death in facility assessments for Resident #10 and Resident #44 were not transmitted within the required 14 day timeframe following each resident's death but stated she had completed it, but it must have not transmitted properly. She revealed facility's failure to complete and transmit required death assessments within mandated timeframes has the potential to affect the accuracy of resident assessment data used for care planning, quality measures, and regulatory compliance. RN #1 presented the state agency with the validation report for Resident #10 dated 9/24/2025 and an MDS for Resident #10 dated 9/18/2025. She presented a validation report for Resident #44 dated 10/02/2025 and an MDS dated 10/02/2025. She was unable to present more up to date documentation that indicated the deaths had been submitted timely and within the required time frames.	F0636		
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F0761		

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F0761 SS = D	Continued from page 4 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and facility policy review, the facility failed to properly store controlled medications for one (1) of four (4) days of survey, which had the potential to allow unauthorized individuals access to controlled substances. Findings include: Record review of the facility policy “Management of Controlled Substances/Medications" with an effective date of September 2025 revealed, “…C. Storage of controlled substances/medications …controlled substances/medications must be stored under two locks... " On 02/04/2026 at 2:41 PM, a review of the facility’s medication storage room revealed a medication refrigerator that lacked an external locking mechanism. Inside the refrigerator was an unlocked, open-top box containing seven (7) vials of Lorazepam 2 mg/1 mL (milligrams/milliliter), a Schedule IV controlled substance classified as a benzodiazepine sedative. In an interview conducted at 2:45 PM on 02/04/26, Licensed Practical Nurse (LPN) #1 confirmed that the refrigerator did not have a locking mechanism and stated that the only lock present was on the door to the medication room. LPN #1 further stated that controlled substances should be secured in a locked box in accordance with regulations to prevent unauthorized access. He stated the refrigerator had been replaced within the past six months and maintenance had not installed a lock. In an interview conducted at 2:55 PM on 02/04/26, the Director of Nursing (DON) confirmed that controlled	F0761		

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F0761 SS = D	Continued from page 5 substances are required to be secured behind two locked barriers. She stated that in this instance, the Lorazepam was only secured behind one locked door (the medication room entrance). The DON stated the purpose of this requirement is to prevent unauthorized access by staff or residents.	F0761		
F0812 SS = D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and facility policy review, the facility failed to ensure staff followed proper hair restraint practices while working in the kitchen. This failure resulted in the Coordinator of Unit creating the potential for hair contamination of food served to residents for one (1) of three (3) survey days. Findings include: A record review of the facility policy, "Food Services Personal Hygiene Habits," effective August 2025, reveals, "...Purpose and Applicability, this policy provides procedures for the required personal hygiene habits of employees who handle food to assist in	F0812		

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F0812 SS = D	Continued from page 6 eliminating the most common sources of food contamination...Procedure...B. Hair restraint (nets) that cover all the hair (including beards) will always be worn while in the pantry. At 9:45 AM on 2/2/26, the State Agency (SA) observed the Coordinator of Unit (COU) working in the facility's kitchen without a hair cover or beard covering while performing his daily tasks. During an interview on 2/2/26 at 9:46 AM, the COU stated that he should wear both a hair net and a beard net because they are hygienic and help ensure he remains sanitary when handling food. On 2/3/26 at 4:07 PM during the interview with the Administrator, she explains that all kitchen staff should wear head and beard coverings when preparing food in the kitchen as this ensures cleanliness and that it is just sanitary to do. She adds not doing so could put residents at risk for food borne illness.	F0812		
F0851 SS = D	Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(p)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(p)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following:	F0851		

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F0851 SS = D	Continued from page 7 (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(p)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(p)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(p)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview the facility failed to accurately submit staffing data to the Payroll Based Journal (PBJ) system for one (1) of four (4) reporting periods reviewed in 2025 (third quarter, July–September 2025). Specifically, the facility failed to ensure that hours worked by licensed nursing staff were correctly coded and reported as direct care nursing hours, resulting in inaccurate PBJ submission data. Findings include: A record review of the Centers for Medicare and Medicaid Services (CMS) Payroll Based Journal report revealed that the facility triggered for insufficient	F0851		

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F0851 SS = D	Continued from page 8 24-hour nursing coverage during the third quarter of 2025 (July through September). A record review of licensed nurse staffing schedules and staffing grids for July through September 2025 revealed no lapses in licensed nurse coverage, indicating that the PBJ report did not accurately reflect actual staffing levels. In an interview conducted at 2:30 PM on 02/03/26, the Director of Nursing (DON) stated she worked frequent overtime shifts providing direct resident care during the third quarter of 2025 due to staffing shortages and limited agency coverage. The DON stated she was unsure whether her time was accurately transferred on timecards for PBJ reporting when she worked as a staff nurse rather than in her administrative role. In an interview conducted at 3:00 PM on 02/04/26, the Human Resources Director, who is responsible for PBJ submissions, stated that the discrepancy involved the Minimum Data Set (MDS) nurse rather than the Director of Nursing (DON). She stated that after reviewing timecards, she identified that licensed nurses are typically coded as “7” for PBJ submission, while the MDS nurse was coded as “6,” which reflects a non-direct care position and does not count toward licensed nursing hours. She stated this coincided with a period beginning on 08/09/25 when the MDS nurse began working additional shifts as a floor nurse to address staffing shortages. In an interview conducted at 8:48 AM on 02/05/26, the MDS nurse (RN #1) confirmed that she began working additional shifts as a floor nurse in August 2025 in addition to her administrative duties but was unsure how her time was coded in the payroll system. She confirmed she worked multiple weekend and weekday shifts during this time. In an interview conducted at 9:00 AM on 02/05/26, the Administrator confirmed that during the survey the facility identified a discrepancy in how the MDS nurse’s time was transferred from the timekeeping system to the PBJ report, resulting in her direct care nursing hours not being reflected accurately. The Administrator stated inaccurate PBJ reporting could impact the facility’s Five-Star rating and funding. She further stated the facility had not received notification from CMS indicating an error prior to the survey.	F0851		
F0880 SS = D	Infection Prevention & Control	F0880		

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F0880 SS = D	Continued from page 9 CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must	F0880		

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F0880 SS = D	Continued from page 10 prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to follow infection prevention and control practices. Specifically, the facility failed to ensure proper glove use and hand hygiene during medication administration via percutaneous endoscopic gastrostomy (PEG) tube for Resident #3 and failed to ensure staff used appropriate hand hygiene and barriers when handling resident food for Resident #16 for two (2) of (13) residents reviewed. Findings Include: Record review of the facility policy “Hand Hygiene” with an effective date of June2025 revealed,” …II. POLICY It is the policy…that all employees will use proper hand hygiene techniques to prevent the spread of infectious diseases…” Resident #3 On 02/04/26 at 12:17 PM, Licensed Practical Nurse (LPN) #2 was observed administering Haloperidol 5 milligrams (mg) via PEG tube to Resident #3. LPN #2 donned gloves turned off the feeding pump and then accessed the PEG tube and administered the medication while wearing the same gloves used to touch the feeding pump. After	F0880		

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F0880 SS = D	Continued from page 11 medication administration, LPN #2 walked to the resident's sink and turned on the water while still wearing the same gloves. On 02/04/26 at 12:46 PM, during an interview, LPN #2 stated she should have changed gloves between touching the feeding pump and accessing the PEG tube. She also stated gloves should have been removed before touching the sink. She acknowledged that failure to follow proper infection control practices could increase the spread of infection. On 02/04/26 at 1:25 PM, during an interview, the Director of Nursing (DON) stated LPN #2 should have changed gloves before accessing the PEG tube and should not have touched the sink with soiled gloves due to the risk of spreading infection to surfaces and residents. Record review of the "Identification and Summary Sheet" revealed an admission date of 1/15/2004 with diagnoses that included schizoaffective disorder. Record review of the February 2026 Medication Administration Record (MAR) revealed Haloperidol 5 mg was initialed as given at 12 PM on 2/4/26 by LPN #2. Resident #16 On 02/02/2026 at 12:54 PM, an observation was conducted of Resident #16 seated in a geri-chair while Certified Nursing Assistant (CNA) #1 assisted with the resident's meal. CNA #1 was observed using bare hands to apply condiments to a hamburger bun, mash the hamburger together, cut the hamburger, pick up pieces of food, and hand them directly to the resident. CNA #1 was also observed passing out additional meal trays to other residents without performing hand hygiene between residents. On 02/02/26 at 1:32 PM, during an interview, CNA #1 stated she believed it was acceptable to touch food with her bare hands if she had sanitized her hands beforehand. She further stated she was told not to use gloves when touching food and acknowledged that this could be an infection control issue. On 02/03/26 at 12:01 PM, during an interview, the DON stated CNA #1 should have worn gloves or used utensils when handling resident food and should not have used bare hands. She stated this was an infection control concern and placed the resident at risk for infection. Record review of Resident #16's "Identification and Summary Sheet" revealed an admission date of 11/21/25.	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A197	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JNH-JAQUITH INN	3550 HIGHWAY 468 WEST , WHITFIELD, Mississippi, 39193

(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
F0880 SS = D	Continued from page 12 Record review of Resident #16's physician orders revealed diagnoses including neurocognitive disorder with behavioral disturbance and blindness, with diet orders for finger foods and allowance for hamburgers at lunch. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/29/26 revealed a Brief Interview for Mental Status (BIMS) score of 3, indicating the resident was severely cognitively impaired.	F0880		