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	08/01/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, record review, interview, and facility policy review, the facility failed to ensure the residents' right to be treated with dignity and respect, as evidenced by staff provided incontinent care without providing privacy for two (2) of four (4) sampled residents. Resident #1 and Resident #2. Findings include:Record review of the facility policy titled, RIGHTS OF RESIDENTS, dated July 2023, revealed .All persons admitted to (Proper name of facility) will be assured that their legal rights will be protected and promoted. The resident will receive care consistent with basic human dignity.The resident has the right to a dignified existence .On 7/30/25 at 9:39 AM, during a pre-survey interview with the Complainant who is the facility Ombudsman stated that during a routine visit at this facility on 6/10/25, she walked down the hallway and noticed two aides with Resident #1 in the hallway and there was something going on that was not right. She stated that it appeared the staff were attempting to provide care for the resident in the hallway and that they put the resident into a Geri-recliner and took her into her room when they noticed her approach. On 7/31/25 at 2:48 PM, observation revealed that Certified Nursing Assistant (CNA) #3 was providing incontinent care for Resident #2 in the resident's room with the door open. There was no privacy curtain in use and the resident's perineal area was exposed. CNA # 3, the CNA Supervisor joined CNA #4 without providing instruction or correction on provision of privacy for incontinent care.On 7/31/25 at 3:00 PM, during an interview CNA #4 confirmed that it was not the correct procedure to provide incontinent care in the hallway and that privacy should be provided to maintain residents' dignity and ensure their rights. She confirmed that the facility provided in-service training regarding residents' rights, including the right to receive care in a dignified manner and incontinent care, including provision of privacy for care.On 7/31/25 at 3:10 PM, during an interview CNA #3 confirmed that she had the authority to provide instruction and correction to CNAs if she observed any problem with care. She said that it was not the correct procedure to provide incontinent care in the hallway and that privacy should be provided to maintain residents' dignity and ensure their rights. She confirmed that the facility provided in-service training regarding residents' rights, including the right to receive care in a dignified manner and incontinent care, including provision of privacy for care. On 7/31/25 at 6:22 PM, during a telephone interview, CNA #1 stated that she and CNA #2 were providing incontinent care for Resident #1 in the hallway outside the doorway of her room on 6/10/25 when the ombudsman came around the corner in the hallway and they took the resident into her room and provided incontinent care. She confirmed that it was not the correct procedure to provide incontinent care in the hallway and that privacy should be provided to maintain residents' dignity and ensure their rights. She confirmed that the facility provided in-service training regarding residents' rights, including the right to receive care in a dignified manner and incontinent care, including provision of privacy for care.On 8/01/25 at 9:20 AM, during an interview the Administrator confirmed that she was notified by a visitor to the facility on 6/10/25 that they had seen something that did not look right. She stated that she had interviewed the two staff involved, CNA #1 and CNA # 2, and that they had denied anything out of the ordinary. She stated she had interviewed Resident #1 and noted no change from baseline and nothing unusual. She said she saw Resident #1 daily and had not noted any change in condition, function or behavior since 6/10/25. She stated that it was not the correct procedure to provide incontinent care in the hallway and that privacy should be provided to maintain residents' dignity and ensure their rights. She confirmed that the facility provided in-service training regarding residents' rights, including the right to receive care in a dignified manner and incontinent care, including provision of privacy for care.On 8/01/25 at 10:15 AM, during an interview Licensed Practical Nurse (LPN) #1 revealed she was the Infection Preventionist (IP) for the facility. She stated that she provided in-service training for nursing staff including incontinent care. She stated she utilized direct observation of incontinent care and other tasks and competency checkoffs for CNA s and nurses. She stated that nursing staff are to take residents to the resident's room, shower room or bathroom to provide incontinent care and that was a big part of treating residents with respect and dignity and an infection control issue. It is not best practice to provide Activities of Daily Living (ADL) care in the hallway, especially incontinent care.On 8/01/25 at 11:32 AM, during a telephone interview, CNA #2 confirmed that Resident #1's incontinent brief was down, and her perineal area was exposed in the hallway when the ombudsman came down the hallway on 6/10/25. She confirmed that it was not the correct procedure to provide incontinent care in the hallway and that privacy should be provided to maintain residents' dignity and ensure their rights. She confirmed that the facility provided in-service training regarding residents' rights, including the right to receive