STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **255249**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **07/28/2026**
NAME OF PROVIDER OR SUPPLIER **COMPERE NH INC**		STREET ADDRESS, CITY, STATE, ZIP CODE **865 NORTH STREET , JACKSON, Mississippi, 39202**	

(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 follow-up revisit at the facility from 7/27/26 through 7/28/26 related to an annual recertification survey that was conducted from 6/08/26 through 6/11/26. The SA found the facility to be in compliance with the requirements of participation in Medicare and Medicaid and recommends the facility be placed back in compliance effective 7/20/28. The facility held a license for 60 beds and the census at the time of the revisit survey was 55 residents.	F0000		

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