

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 07/28/2026	
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
M0000	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 6/08/26 through 6/11/26. The SA determined the facility was in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirement and recommends the facility be placed back in compliance effective 7/20/28.			M0000			

Office of Primary Care and Health Systems Management

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