

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255336		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/20/2026	
NAME OF PROVIDER OR SUPPLIER JONES CO REST HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 683 COUNTY HOME ROAD , ELLISVILLE, Mississippi, 39437			
(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 survey and Complaint Investigation (CI MS #3166632), at the facility from 8/17/26 through 8/20/26. CI MS #3166632 was investigated related to admission rights and there were no citations related to the complaint. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F583, F584, F605, F628, F641, F656, F658, F689, F756, F761, and F880. The facility had a census of 119 and was licensed for 122 beds.			F0000			
F0583 SS = D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records.			F0583			

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
---	--	-------	-----------

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255336		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/20/2026	
NAME OF PROVIDER OR SUPPLIER JONES CO REST HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 683 COUNTY HOME ROAD , ELLISVILLE, Mississippi, 39437			
(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	
F0583 SS = D	Continued from page 1 (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to ensure residents' rights related to privacy for two (2) of (24) sampled residents. Resident #53 and Resident #105. Findings include: A review of the facility's "Notice of Privacy Practices for Protected Health Information", dated July 2022, revealed, "...Our Responsibilities... (Proper Name of Facility) is dedicated to protecting your medical information. We are required by law to maintain the privacy of protected health information..." Resident #53 On 08/18/2026 at 8:26 AM, during an observation of the medication cart on the 500-hall the computer screen was unlocked, and Resident #53's Medication Administration Record (MAR) was visible on the screen. The MAR displayed private health information related to medications prescribed to Resident #53 and was visible to anyone who was walking in the hallways. Licensed Practical Nurse (LPN) #2 was not at the medication cart and was inside Resident #53's room. On 08/18/2026 at 8:29 AM, during an interview with (LPN) #2 she revealed that she meant to lock the computer screen, but the resident called her and she got in a hurry and didn't do it. LPN #2 reported that the importance of keeping the screen locked is to protect the residents' privacy. LPN #2 stated she will lock the screen in the future. On 08/18/2026 at 8:32 AM, during an interview with the Registered Nurse (RN) #1 she was informed of the medication carts' computer screen being unlocked with Resident #53's MAR visible on the screen. RN #1 revealed the staff are trained at the facility to be careful to protect the residents' privacy. RN#1 stated it is important to keep the	F0583					

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255336		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/20/2026	
NAME OF PROVIDER OR SUPPLIER JONES CO REST HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 683 COUNTY HOME ROAD , ELLISVILLE, Mississippi, 39437			
(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
F0583 SS = D	Continued from page 2 residents' information private because they may not want other people to know their medications or what they are taking them for. The RN affirmed she expects the nurses to protect the residents' privacy. On 08/20/2026 at 9:15 AM, during an interview with the Director of Nursing (DON) he revealed that he was made aware of the computer screen left unlocked on the medication cart and that Resident #53's MAR was exposed to anyone walking down the hall. The DON stated the facility reviews privacy with the staff. The DON affirmed that this was a violation of Resident #53's privacy and that the resident may not want everyone to know her information. The DON reported that he expects the staff to lock the computer screen when not in use. A record review of the "Admission Record" revealed the facility admitted Resident #53 on 07/24/2026 with diagnoses including Unspecified Fracture of Right Femur. A record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/30/2026 revealed Resident #53 had a Brief Interview for Mental Status (BIMS) score of 14 indicating she was cognitively intact. Resident #105 On 8/18/26 at 9:40 AM, during an observation of Resident #105's room, there was signage posted on the wall above the resident's bed instructing staff to "Apply barrier cream after each brief change." The words on the signage were highlighted in blue. On 8/20/26 at 11:00 AM, a telephone interview with Resident #105's Resident Representative, daughter, and Power of Attorney (POA) revealed the signage had been posted above the resident's bed following a discussion with a nurse regarding a reddened area on the resident's buttocks. The representative stated she observed the redness and expressed concern that staff were not applying barrier cream following episodes of incontinence care. She stated an unidentified nurse posted the signage approximately one year earlier. The representative further stated that when family members prepared to take a photograph with the resident in the room, she instructed them to remove the sign before taking the photograph because she believed the signage compromised the resident's privacy. On 8/20/26 at 11:45 AM, an interview with LPN #6 revealed she believed the signage had been requested by the resident's daughter. When			F0583			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255336		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/20/2026	
NAME OF PROVIDER OR SUPPLIER JONES CO REST HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 683 COUNTY HOME ROAD , ELLISVILLE, Mississippi, 39437			
(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
F0583 SS = D	Continued from page 3 informed that the resident's daughter reported a nurse had posted the sign, LPN #6 stated the signage may have been posted before she assumed her current position. LPN #6 stated she had observed the signage above the resident's bed for approximately one year and had not posted it. LPN #6 further stated Certified Nursing Assistants (CNAs) could access the resident's care instructions through the electronic health record. On 8/20/26 at 11:56 AM, an interview with CNA #2 revealed she had provided care to Resident #105 during the survey week. CNA #2 stated the signage had been posted above the resident's bed for as long as she had provided care to the resident. CNA #2 further stated staff could access the resident's care instructions through the electronic health record and the care plan/Kardex to determine when barrier cream was to be applied. On 8/20/26 at 12:14 PM, an interview with the DON revealed CNAs could access Resident #105's care instructions through the care plan or Kardex, including instructions to apply barrier cream following episodes of incontinence care, without posting the resident's individualized care information on the wall above the bed. The DON stated his expectation was for staff not to post residents' medical or care information on the walls of resident rooms and to utilize the Care plan and Kardex to obtain resident-specific care instructions. A record review of the "Admission Record" revealed the facility admitted Resident #105 on 7/17/2019 and she had diagnoses including Hemiplegia and Hemiparesis following Nontraumatic Intracerebral Hemorrhage Affecting Right Dominant Side. A record review of the Quarterly MDS with an ARD of 7/22/2026 revealed Resident #105 did not receive a BIMS interview because she rarely/never understood. A record review of the "Care Plan Report" revealed Resident #105 had a care plan "Focus" of "Skin" with an intervention to "apply preventative silicone cream to buttocks after brief changes for prevention of skin breakdown."			F0583			
F0584 SS = D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable			F0584			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255336		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/20/2026	
NAME OF PROVIDER OR SUPPLIER JONES CO REST HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 683 COUNTY HOME ROAD , ELLISVILLE, Mississippi, 39437			
(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	
F0584 SS = D	Continued from page 4 and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to ensure residents' rights related to a clean, sanitary, and homelike environment for two (2) of (24) sampled residents. Resident #10 and Resident #20. Findings include:	F0584					

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255336		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/20/2026	
NAME OF PROVIDER OR SUPPLIER JONES CO REST HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 683 COUNTY HOME ROAD , ELLISVILLE, Mississippi, 39437			
(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	
F0584 SS = D	Continued from page 5 A review of the facility's "Environmental Services Policy," revised 7/1/2024, revealed, "...The Environmental Services department (EVS)...shall have processes in place to maintain an sanitary environment that will assist in the prevention and control of infections and communicable diseases...Procedure Sanitation within the hospital environment depends on cleaning thoroughness and frequency. There shall be procedures for cleaning walls, floors, windows, beds, furniture, carpets, waste containers, bathrooms, and other surfaces for patient care areas and non-patient areas. 1. Patient Rooms...Bathrooms shall be cleaned daily with an approved disinfectant with special attention given to toilets, bars, handles, and doorknobs..." On 8/18/26 at 9:34 AM, during an observation and interview, Resident #10 revealed that Environmental Services (EVS) staff did not clean the resident's bathroom daily. In the bathroom shared by Residents #10 and #20, there was a pink-colored ring and circular areas of brown discoloration inside the toilet bowl. Dark brown specks of adhered residue were also observed on the interior surface of the toilet bowl. The bathroom floor was dirty. On 8/19/26 at 11:38 AM, during an interview and observation of the bathroom shared by Residents #10 and #20, the same discolored areas and adhered residue previously identified were inside the toilet bowl, along with the pink and brown rings around the bowl. An interview with Resident #20 revealed EVS had entered the bathroom and removed the trash but had not performed additional cleaning. On 8/19/26 at 2:39 PM, an interview with Housekeeping #1 (HSK #1), Environmental Services Supervisor, revealed EVS staff were expected to clean resident rooms daily. HSK #1 stated daily cleaning included removing trash and cleaning toilets and baseboards. HSK #1 further stated EVS staff performed more extensive cleaning of resident rooms on designated deep-cleaning days and completed a skills competency checklist in February 2026 that included cleaning bathrooms according to facility protocol. HSK #1 stated the pink discoloration observed inside the toilet bowl in Resident #10 and Resident #20's toilet, the pink rings were reportedly associated with fungus or mold. HSK #1 further stated room cleanliness was discussed during stand-up meetings at least weekly and confirmed she was aware of resident complaints regarding room cleaning. On 8/20/26 at 8:43 AM, during an interview, the Administrator stated she was aware that residents	F0584					

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255336		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/20/2026	
NAME OF PROVIDER OR SUPPLIER JONES CO REST HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 683 COUNTY HOME ROAD , ELLISVILLE, Mississippi, 39437			
(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
F0584 SS = D	Continued from page 6 had complained about their rooms not being cleaned prior to the survey. The Administrator stated the rings observed inside the toilet bowls were caused by mineral and calcium buildup from the facility's water supply. She stated staff, including herself, had attempted to remove the rings without success and believed the toilet bowls might need to be replaced. The Administrator stated she expected Environmental Services (EVS) staff to clean resident rooms and bathrooms and maintain them in a sanitary and homelike condition, including cleaning mirrors, windows, and other surfaces. She stated Certified Nursing Assistants (CNAs) were expected to remove paper and other debris from resident floors and tidy resident rooms as needed. Resident #10 A record review of the "Admission Record" revealed the facility admitted Resident #10 on 4/8/2026 with diagnoses including Chronic Kidney Disease. A record review of the Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/8/2026 revealed Resident #10 had a Brief Interview for Mental Status (BIMS) score of 14, indicating her cognition was intact. Resident #20 A record review of the "Admission Record" revealed the facility admitted Resident #20 on 7/31/2026 with diagnoses including Hemiplegia and Hemiparesis following Cerebral Infarction Affecting the Right Dominant Side. A record review of the Comprehensive MDS with an ARD of 8/6/2026 revealed Resident #20 had a BIMS score of 15, indicating her cognition was intact.			F0584			
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the			F0605			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255336		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/20/2026	
NAME OF PROVIDER OR SUPPLIER JONES CO REST HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 683 COUNTY HOME ROAD , ELLISVILLE, Mississippi, 39437			
(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	
F0605 SS = D	Continued from page 7 resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- . . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or	F0605					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255336	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/20/2026	
NAME OF PROVIDER OR SUPPLIER JONES CO REST HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 683 COUNTY HOME ROAD , ELLISVILLE, Mississippi, 39437		
(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	
F0605 SS = D	Continued from page 8 (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to ensure appropriate	F0605			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255336		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/20/2026	
NAME OF PROVIDER OR SUPPLIER JONES CO REST HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 683 COUNTY HOME ROAD , ELLISVILLE, Mississippi, 39437			
(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
F0605 SS = D	Continued from page 9 use of psychotropic medications by continuing an as-needed (PRN) psychotropic medication beyond 14 days without documented clinical rationale from the prescribing practitioner supporting continued use of the medication and without documentation identifying the duration of the PRN order for one (1) of six (6) residents reviewed for unnecessary medications. (Resident #104). Findings include: A record review of the facility's policy titled, "Medication Regimen Review (MRR) and Psychotropic Medication Use Policy," reviewed 08/06/2026, revealed, "...It is the policy of this facility that each resident's medication regimen will be monitored and managed to promote highest function and well-being and is free from unnecessary drugs ... Procedure: ... 3. The MMR includes review of the medical record in order to prevent, identify, report, and resolve medication-related problems, medication errors, or other irregularities ... 6. Any irregularities identified during the MRR will be documented using the MRR Communication Form which will be provided to the physician and the Director of Nursing (DON) within 10 working days of the review ... Unnecessary Drugs and Review of Psychotropic Medication during MRR: ... 5. PRN (as needed) orders for psychotropic drugs are limited to 14 days, unless the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days. He or she should document their rationale in the resident's medical record and indicate the duration for the PRN order ..." On 08/19/2026 at 3:31 PM, during an interview, Certified Nursing Assistant (CNA) #1 stated Resident #104 required assistance from two staff members for activities of daily living and was sometimes combative or aggressive during care. CNA #1 stated when the resident became combative during care, she notified the nurse and the nurse sometimes administered medication to calm the resident. On 08/19/2026 at 3:44 PM, during an interview, Licensed Practical Nurse (LPN) #4 stated Resident #104 had an as-needed order for Ativan (Lorazepam). LPN #4 stated she last administered the medication the previous week when the resident was fighting and screaming at staff during care. LPN #4 stated the resident sometimes became agitated during care, particularly on shower days, and could spit, pinch, scratch staff, and refuse care. On 08/19/2026 at 4:35 PM, during an interview, the			F0605			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255336		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/20/2026	
NAME OF PROVIDER OR SUPPLIER JONES CO REST HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 683 COUNTY HOME ROAD , ELLISVILLE, Mississippi, 39437			
(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
F0605 SS = D	Continued from page 10 Consultant Pharmacist stated she reviewed residents' medication regimens monthly and reported findings and recommendations to the Director of Nursing (DON). The Consultant Pharmacist stated she was unaware that PRN orders for psychotropic medications were limited to 14 days unless the prescribing practitioner documented the rationale for extending the order and identified the duration of the order. On 08/20/2026 at 3:00 PM, during an interview and review of Resident #104's medical record, the DON stated he was aware of the 14-day limitation for PRN psychotropic medications but believed an exception applied to residents receiving hospice or palliative care. The DON confirmed Resident #104's PRN Lorazepam order was dated 04/16/2026 and the facility could not provide documentation that the prescribing practitioner had evaluated the continued use of the medication, documented a rationale for extending the PRN order beyond 14 days, or identified the duration of the extended order. The DON further confirmed the Consultant Pharmacist had not identified the continued PRN order as a medication irregularity. On 08/20/2026 at 3:10 PM, during an interview, the Administrator stated she was aware of the requirements governing PRN psychotropic medications, including the 14-day limitation, and expected facility staff, prescribing practitioners, and the Consultant Pharmacist to follow requirements related to psychotropic medication use. A record review of Resident #104's "Admission Record" revealed the facility initially admitted the resident on 05/07/2013 and readmitted the resident on 09/01/2023 with diagnoses including Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side and Chronic Kidney Disease (CKD). A record review of Resident #104's "Order Summary Report," with active orders as of 08/19/2026, revealed an order for comfort measures related to Chronic Kidney Disease (CKD) and an order dated 04/16/2026 for Lorazepam Oral Concentrate 1 milligram (mg)/0.5 milliliter (mL), give 0.5 mL orally every six hours as needed for anxiety. A record review of Resident #104's Medication Administration Records (MARs) from April through August 2026 revealed PRN Lorazepam was administered on 04/22/2026; 05/01/2026; 05/05/2026; 05/11/2026; 05/12/2026; 05/15/2026; 05/18/2026; 05/20/2026; 05/24/2026; 05/28/2026;			F0605			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255336		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/20/2026	
NAME OF PROVIDER OR SUPPLIER JONES CO REST HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 683 COUNTY HOME ROAD , ELLISVILLE, Mississippi, 39437			
(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	
F0605 SS = D	Continued from page 11 06/05/2026; 06/10/2026; 06/12/2026; 06/15/2026; 06/16/2026; 06/30/2026; 07/17/2026; 07/24/2026; 07/26/2026; 08/10/2026; and 08/12/2026. A record review of Resident #104's medical record revealed no documented rationale from the prescribing practitioner supporting continuation of the PRN Lorazepam order beyond 14 days or documentation identifying the duration of the extended PRN order.		F0605				
F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language		F0628				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255336		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/20/2026	
NAME OF PROVIDER OR SUPPLIER JONES CO REST HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 683 COUNTY HOME ROAD , ELLISVILLE, Mississippi, 39437			
(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
F0628 SS = D	Continued from page 12 and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights,			F0628			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255336		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/20/2026	
NAME OF PROVIDER OR SUPPLIER JONES CO REST HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 683 COUNTY HOME ROAD , ELLISVILLE, Mississippi, 39437			
(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	
F0628 SS = D	Continued from page 13 including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing	F0628					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255336		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/20/2026	
NAME OF PROVIDER OR SUPPLIER JONES CO REST HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 683 COUNTY HOME ROAD , ELLISVILLE, Mississippi, 39437			
(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
F0628 SS = D	Continued from page 14 facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to ensure written transfer notifications provided to a Resident Representative (RR) that included the specific reason for transfer in a language and manner the representative could understand for one (1) of four			F0628			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255336		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/20/2026	
NAME OF PROVIDER OR SUPPLIER JONES CO REST HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 683 COUNTY HOME ROAD , ELLISVILLE, Mississippi, 39437			
(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	
F0628 SS = D	Continued from page 15 (4) residents reviewed for hospitalization. (Resident #76). Findings include: A record review of the facility's policy titled, "Resident Transfer and Discharge Policy," reviewed 08/11/2026, revealed, "...6.b. The Business Office Staff will notify the resident and the resident's representative in writing in a language and manner they understand..." A record review of Resident #76's "Admission Record" revealed the facility initially admitted the resident on 09/16/2021 and readmitted the resident on 02/21/2023 with diagnoses including Chronic Kidney Disease, Stage 3 Unspecified, and Benign Prostatic Hyperplasia without Lower Urinary Tract Symptoms. A record review of Resident #76's "Care Profile" revealed discharge assessments with return anticipated dated 05/21/2026 and 07/16/2026. A record review of Resident #76's "View Progress Note" dated 05/21/2026 at 4:16 PM revealed the resident was not eating or drinking appropriately, was slow to respond to questions, was lethargic, and cried out when the resident's legs were touched. The progress note documented the resident was transferred to the emergency room. A record review of Resident #76's "Notice of Resident Transfer or Discharge" dated 05/21/2026 at 6:22 PM revealed the form did not document the specific reason for the resident's transfer. A record review of Resident #76's "Discharge Return Anticipated Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 05/21/2026, revealed the resident experienced an unplanned discharge to an acute short-term general hospital. A record review of Resident #76's "View Progress Note" dated 07/16/2026 at 12:33 PM revealed the resident was moaning and not responding to verbal stimuli, with the resident's head and eyes deviated to the left and blood pressure documented as 54/38 by machine and 78/40 manually. The progress note documented report was provided to (Proper Name). A record review of Resident #76's "Notice of Resident Transfer or Discharge" dated 07/16/2026 at 12:39 PM revealed the form did not document the specific reason for the resident's transfer.	F0628					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255336		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/20/2026	
NAME OF PROVIDER OR SUPPLIER JONES CO REST HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 683 COUNTY HOME ROAD , ELLISVILLE, Mississippi, 39437			
(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
F0628 SS = D	Continued from page 16 A record review of Resident #76's "Discharge Return Anticipated MDS," with an ARD of 07/16/2026, revealed the resident experienced an unplanned discharge to an acute short-term general hospital. On 08/17/2026 at 4:00 PM, during a telephone interview, Resident #76's RR stated facility staff routinely called her when the resident experienced changes in condition or was transferred to the hospital. The RR stated Resident #76 had been transferred to the hospital several times and she could not recall receiving written transfer notifications. On 08/19/2026 at 1:38 PM, during an interview, the Director of Nursing (DON) stated the charge nurse was responsible for completing the "Notice of Resident Transfer or Discharge" when a resident was transferred to the hospital and stated the specific reason for the transfer was expected to be documented on the form. On 08/19/2026 at 1:46 PM, during an interview, Registered Nurse (RN) #3 stated the "Notice of Resident Transfer or Discharge" was the form mailed to the resident's representative. RN #3 stated front-office staff printed the completed form and mailed it to the RR. On 08/20/2026 at 2:24 PM, during an interview, RN #2 stated when a resident was transferred to the hospital, nursing staff completed the transfer form and were expected to document the specific reason for the transfer using language the resident or RR could understand. On 08/20/2026 at 2:50 PM, during an interview and record review of Resident #76's transfer documentation, the Business Office Coordinator stated she was responsible for mailing written transfer notifications to the RRs. The Business Office Coordinator stated nursing staff were responsible for completing the transfer forms at the time of transfer and acknowledged there had been a pattern of nurses not completing the section identifying the specific reason for transfer. She stated office staff attempted to add the missing information before mailing the notices; however, the facility did not retain copies of the notices after information was added. The Business Office Coordinator reviewed Resident #76's transfer forms dated 05/21/2026 and 07/16/2026 and confirmed neither form documented the specific reason for transfer.			F0628			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255336		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/20/2026	
NAME OF PROVIDER OR SUPPLIER JONES CO REST HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 683 COUNTY HOME ROAD , ELLISVILLE, Mississippi, 39437			
(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
F0628 SS = D	Continued from page 17 On 08/20/2026 at 3:00 PM, during an interview, the Business Office Assistant stated she assisted with mailing written transfer notifications and was aware that transfer forms were sometimes missing the specific reason residents were transferred to the hospital. She stated office staff attempted to identify and correct missing information before mailing the forms; however, the facility did not retain a copy of the completed form when information was subsequently added. On 08/20/2026 at 3:10 PM, during an interview, the Administrator stated the charge nurse was responsible for completing the transfer notification and expected all required information to be included before the notice was mailed to the RR.			F0628			
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment.			F0641			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255336		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/20/2026	
NAME OF PROVIDER OR SUPPLIER JONES CO REST HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 683 COUNTY HOME ROAD , ELLISVILLE, Mississippi, 39437			
(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	
F0641 SS = D	Continued from page 18 §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to accurately code a Minimum Data Set (MDS) assessment as evidenced by coding a resident as having expired in the facility when the resident had been transferred to and subsequently expired in the hospital for one (1) of three (3) closed-record residents reviewed for MDS accuracy. (Resident #123). Findings include: A record review of the facility's policy titled, "MDS (Minimum Data Set), CAA (Care Area Assessment), and Care Plan Documentation Policy," reviewed 08/06/2026, revealed, "...The staff completing each portion of the MDS is responsible for ensuring that documentation is found in the medical record to support the coding they perform..." A record review of Resident #123's "Admission Record" revealed the facility admitted the resident on 04/04/2025 with diagnoses including Type 2 Diabetes Mellitus with Unspecified Complications and Essential (Primary) Hypertension. A record review of Resident #123's "Order Summary Report" revealed an order dated 07/06/2026 to transfer the resident to the Emergency Room (ER). A record review of Resident #123's "View Progress Note," dated 07/06/2026 at 9:17 AM, revealed, "...at 07:45 Resident seen by (Proper Name) Physician ... ordered to send to ER (Emergency Room) for further treatment..." A record review of Resident #123's "Discharge Return Anticipated MDS," with an Assessment Reference Date (ARD) of 07/06/2026, revealed the resident experienced an unplanned discharge to an acute short-term general hospital. A record review of Resident #123's "Death in Facility MDS," with an ARD of 07/08/2026, revealed the resident was coded as having died in the facility. On 08/19/2026 at 3:31 PM, during an interview, Registered Nurse (RN) #2 stated Resident #123 was transferred to the hospital on 07/06/2026 and subsequently died at the hospital without returning to the facility.	F0641					

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255336		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/20/2026	
NAME OF PROVIDER OR SUPPLIER JONES CO REST HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 683 COUNTY HOME ROAD , ELLISVILLE, Mississippi, 39437			
(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	
F0641 SS = D	Continued from page 19 On 08/20/2026 at 2:10 PM, during an interview and review of Resident #123's MDS assessments, Licensed Practical Nurse (LPN) #3 stated she was responsible for completing MDS assessments. LPN #3 reviewed Resident #123's discharge and death assessments and confirmed the resident was transferred to the hospital and died at the hospital two days later. LPN #3 confirmed the "Death in Facility MDS" was completed in error and stated she would complete a corrected MDS assessment. LPN #3 stated the facility did not conduct an accuracy review of MDS assessments prior to submission and individual staff members were responsible for ensuring the accuracy of the portions they completed. On 08/20/2026 at 3:00 PM, during an interview, the Administrator stated she expected residents' MDS assessments to be accurately completed at the time of submission. The Administrator confirmed Resident #123 died at the hospital and the "Death in Facility MDS" was completed in error.	F0641					
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical	F0656					

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255336		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/20/2026	
NAME OF PROVIDER OR SUPPLIER JONES CO REST HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 683 COUNTY HOME ROAD , ELLISVILLE, Mississippi, 39437			
(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	
F0656 SS = D	Continued from page 20 record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews, and record review, the facility failed to develop a comprehensive, person-centered care plan that included specific interventions to address the care needs associated with a resident's nephrostomy insertion site, including cleansing and dressing care for one (1) of (24) residents reviewed for comprehensive care plans. (Resident #8). Findings include: A record review of Resident #8's "Care Plan Report" revealed a focus related to the nephrostomy tube for urinary drainage, which identified the resident was at risk for infection, obstruction, accidental dislodgement, skin breakdown, and impaired urinary elimination. Interventions included monitoring the nephrostomy tubes for patency and freedom from kinks every shift, maintaining the collection bag below kidney level, and monitoring the insertion sites for signs of infection and leakage. The care plan did not include interventions directing staff regarding cleansing, dressing changes, or other site care for the resident's nephrostomy insertion site. On 08/19/2026 at 9:43 AM, during an interview, Licensed Practical Nurse (LPN) #7 stated Resident #8 had a nephrostomy catheter with a dressing at the insertion site. LPN #7 stated nurses were responsible for emptying the nephrostomy collection	F0656					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255336		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/20/2026	
NAME OF PROVIDER OR SUPPLIER JONES CO REST HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 683 COUNTY HOME ROAD , ELLISVILLE, Mississippi, 39437			
(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
F0656 SS = D	Continued from page 21 bag and documenting urinary output and stated the wound care nurse changed the dressing daily and the floor nurse changed the dressing as needed. On 08/19/2026 at 2:15 PM, during an observation of nephrostomy-site care for Resident #8, LPN #7 removed the dressing from the resident's nephrostomy insertion site, cleansed the insertion site with normal saline using a circular motion from the insertion site outward, and applied a dry dressing. On 08/20/2026 at 9:43 AM, during an interview, LPN #8 stated she had previously provided nephrostomy-site care to Resident #8 by cleansing the insertion site with normal saline and applying a dry dressing. On 08/20/2026 at 11:25 AM, during an interview and review of Resident #8's care, the Director of Nursing (DON) confirmed the resident required nephrostomy-site care. A record review of Resident #8's "Admission Record" revealed the facility admitted the resident on 10/16/2025 with diagnoses including Other Artificial Openings of Urinary Tract Status, Chronic Kidney Disease Stage 2, and Unspecified Hydronephrosis. A record review of Resident #8's "Order Summary Report" revealed active physician orders to monitor the nephrostomy tubes for patency and freedom from kinks every shift, monitor the nephrostomy-tube insertion sites for signs of infection, including redness, swelling, warmth, discharge, odor, and leakage every shift, and monitor urinary output every shift. A record review of Resident #8's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/30/2026, revealed a Brief Interview for Mental Status (BIMS) score of 4, which indicated severe cognitive impairment. Section H0100, Appliances, identified use of an indwelling catheter, including a nephrostomy tube. A record review of Resident #8's "History and Physical," dated 05/27/2026, revealed the assessment and plan documented "routine nephrostomy care."			F0656			
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)			F0658			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255336		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/20/2026	
NAME OF PROVIDER OR SUPPLIER JONES CO REST HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 683 COUNTY HOME ROAD , ELLISVILLE, Mississippi, 39437			
(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	
F0658 SS = D	Continued from page 22 §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews, record review, Mississippi Nursing Practice Law review and Mississippi Board of Nursing review the facility failed to ensure nursing services were provided in accordance with professional standards of practice by providing nephrostomy-site treatment without a medical order specifying the treatment to be provided and failing to document nephrostomy-site care that was provided to the resident for one (1) of (24) residents reviewed for nursing services. (Resident #8). Findings include: A review of the Mississippi Nursing Practice Law, Mississippi Code §73-15-5, revealed "...Definitions...5. the practice of nursing by a licensed practical nurse...services are performed under the direction of a registered nurse or a licensed physician or licensed dentist... the administration of medications and treatments prescribed by a licensed physician or licensed dentist authorized by state law to prescribe..." A review of the Mississippi Board of Nursing's guidance regarding nursing documentation revealed, "...Documentation of all nursing activities should be clear, concise, complete and contemporaneous with the activity/observation. The documentation should be done as soon as possible after the activity is performed..." A review of the Mississippi Board of Nursing's "Frequently Asked Questions" regarding licensed nursing practice revealed the licensed nurse was responsible for providing nursing care consistent with the nurse's education and that performance of nursing procedures was subject to basic requirements, including, "...There is a medical order for the procedure..." On 08/19/2026 at 2:15 PM, during an observation of nephrostomy-site care for Resident #8, a Licensed Practical Nurse (LPN) #7 removed the dressing from the resident's nephrostomy insertion site, cleansed the insertion site with normal saline using a circular motion from the insertion site outward, and applied	F0658					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255336		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/20/2026	
NAME OF PROVIDER OR SUPPLIER JONES CO REST HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 683 COUNTY HOME ROAD , ELLISVILLE, Mississippi, 39437			
(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
F0658 SS = D	Continued from page 23 a dry dressing. On 08/19/2026 at 2:27 PM, during an interview and review of Resident #8's physician orders, LPN #7 confirmed the resident's medical record did not contain a physician order specifying nephrostomy-site treatment or dressing care. LPN #7 confirmed she had performed the observed nephrostomy-site care by cleansing the insertion site with normal saline and applying a dry dressing despite the absence of an order specifying the treatment to be provided. On 08/20/2026 at 9:35 AM, during an interview and review of Resident #8's physician orders, Registered Nurse (RN) #4 confirmed there was no physician order specifying treatment or dressing care for Resident #8's nephrostomy insertion site. On 08/20/2026 at 9:43 AM, during an interview, LPN #7 stated she had previously provided nephrostomy-site care to Resident #8 by cleansing the site with normal saline and applying a dry dressing. LPN #7 stated she believed there had been an order for the treatment at that time. On 08/20/2026 at 11:25 AM, during an interview and review of Resident #8's care, the Director of Nursing (DON) stated the resident required nephrostomy-site care and confirmed there was no physician order specifying the nephrostomy-site care to be provided. On 08/20/2026 at 12:25 PM, during an interview, the Administrator stated residents with ostomy sites requiring site care should have physician orders specifying the care to be provided. A record review of Resident #8's "Admission Record" revealed the facility admitted the resident on 10/16/2025 with diagnoses including Other Artificial Openings of Urinary Tract Status, Chronic Kidney Disease Stage 2, and Unspecified Hydronephrosis. A record review of Resident #8's "Order Summary Report" revealed active physician orders to monitor the nephrostomy tubes for patency and freedom from kinks every shift, monitor the nephrostomy-tube insertion sites for signs of infection, including redness, swelling, warmth, discharge, odor, and leakage every shift, and monitor urinary output every shift. The Order Summary Report did not contain a physician order specifying treatment or dressing care for the nephrostomy-tube insertion site.			F0658			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255336	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/20/2026	
NAME OF PROVIDER OR SUPPLIER JONES CO REST HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 683 COUNTY HOME ROAD , ELLISVILLE, Mississippi, 39437		
(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
F0658 SS = D	Continued from page 24 A record review of Resident #8's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/30/2026, revealed a Brief Interview for Mental Status (BIMS) score of 4, which indicated severe cognitive impairment. Section H0100, Appliances, identified use of an indwelling catheter, including a nephrostomy tube. A record review of Resident #8's "Care Plan Report" revealed a focus related to the nephrostomy tube for urinary drainage, which placed the resident at risk for infection, obstruction, accidental dislodgement, skin breakdown, and impaired urinary elimination. Interventions included monitoring the nephrostomy tubes for patency and freedom from kinks every shift, maintaining the collection bag below kidney level, and monitoring the insertion sites for signs of infection and leakage. The care plan did not identify a specific treatment procedure for cleansing or dressing the nephrostomy insertion site. A record review of Resident #8's "History and Physical," dated 05/27/2026, revealed the assessment and plan documented "routine nephrostomy care," without further direction specifying the method, cleansing solution, dressing, or frequency of nephrostomy-site care. A record review of Resident #8's medical record revealed no documentation that nephrostomy-site care had been performed, including cleansing of the insertion site or dressing changes.	F0658			
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews, record review, and review of the manufacturer's instructions, the facility failed to ensure a resident received assistance with transfers in a manner that minimized the risk for accidents as evidenced by, using a mechanical lift	F0689			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255336		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/20/2026	
NAME OF PROVIDER OR SUPPLIER JONES CO REST HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 683 COUNTY HOME ROAD , ELLISVILLE, Mississippi, 39437			
(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
F0689 SS = D	Continued from page 25 as a transport device to move the resident while suspended in a full-body sling across the hallway and into the resident's room, contrary to the mechanical lift manufacturer's safety instructions for one (1) of two (2) residents reviewed for accident hazards. (Resident #113). Findings include: A review of the manufacturer's instructions for the Invacare RPL600-2 mechanical lift revealed, "...WARNING! The Invacare patient lift is NOT a transport device. It is intended to transfer an individual from one resting surface to another (such as a bed to a wheelchair)..." On 08/17/2026 at 2:05 PM, during an observation in the hallway, two Certified Nurse Aides (CNAs) prepared to transfer Resident #113 from a geri-chair using a mechanical lift and full-body sling. One CNA obtained a third CNA to assist. The three CNAs raised Resident #113 from the geri-chair until the resident was suspended in the sling. While Resident #113 remained suspended in the sling, staff rotated the mechanical lift approximately 180 degrees and moved the resident across the hallway, through the doorway of the resident's room, and toward the resident's bed. The third CNA left after the mechanical lift entered the resident's room, and the remaining two CNAs lowered Resident #113 onto the bed. An observation of Resident #113's room revealed sufficient space to accommodate the geri-chair and mechanical lift. On 08/17/2026 at 2:05 PM, during an interview with CNA #4 and CNA #5, following the observation, CNA #4 stated she had been trained to transfer residents from geri-chairs in this manner. CNA #4 acknowledged that it would be safer to transfer a resident directly from one surface to another without transporting the resident while suspended in the mechanical lift; however, she stated this was how staff had always performed the transfer and how she had been trained by another CNA. CNA #5 stated this was her first time transferring Resident #113. CNA #5 stated staff routinely used the mechanical lift in the hallway to move residents who used geri-chairs. On 08/19/2026 at 9:35 AM, during an interview, Licensed Practical Nurse (LPN) #7 stated Resident #113 was dependent on staff for activities of daily living and required assistance from two staff members and a mechanical lift for transfers. On 08/19/2026 at 4:00 PM, during an interview, the			F0689			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255336		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/20/2026	
NAME OF PROVIDER OR SUPPLIER JONES CO REST HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 683 COUNTY HOME ROAD , ELLISVILLE, Mississippi, 39437			
(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	
F0689 SS = D	Continued from page 26 Director of Nursing (DON) stated he had provided staff education on proper mechanical-lift techniques on 07/30/2026. The DON stated the training addressed use of two staff members during mechanical-lift transfers, selection of the appropriate lift-pad size, and performing transfers as close to the bed or wheelchair as possible to minimize risk. During the continued interview at 4:07 PM, the DON confirmed Resident #113 required assistance from two staff members and a mechanical lift for transfers. The DON stated transporting a resident from a geri-chair located in the hallway into the resident's room while suspended in the mechanical lift was not ideal and that transfers should occur as close to the bed or wheelchair as possible to decrease potential risks associated with the transfer. The DON confirmed Resident #113 had not experienced a recent fall or injury. On 08/20/2026 at 9:15 AM, during an interview, CNA #7 and CNA #8 stated they had conducted mechanical-lift training for nursing staff from 10/01/2025 through 10/03/2025. They stated the training included the requirement for two-person assistance during mechanical-lift transfers, selection of the appropriate lift-pad size, and return demonstration of the transfer procedure. CNA #7 and CNA #8 stated mechanical-lift transfers were expected to occur in the resident's room from one transfer surface to another for resident safety and dignity. On 08/20/2026 at 12:40 PM, during an interview, the Administrator stated resident transfers using a mechanical lift should occur as close to the transfer surfaces as possible. A record review of Resident #113's "Admission Record" revealed the facility admitted the resident on 03/15/2017 with diagnoses including Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side and Unspecified Dementia. A record review of Resident #113's Annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/21/2026, revealed a Brief Interview for Mental Status (BIMS) score of 9, which indicated moderate cognitive impairment. A record review of Resident #113's "Care Plan Report" revealed a focus related to functional abilities with an intervention directing staff, "Transfer: Dependent X 2 staff with mechanical lift via medium full body lift pad (Purple or Yellow trim)."	F0689					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255336		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/20/2026	
NAME OF PROVIDER OR SUPPLIER JONES CO REST HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 683 COUNTY HOME ROAD , ELLISVILLE, Mississippi, 39437			
(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	
F0756 SS = D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to ensure the Consultant Pharmacist identified and reported a medication irregularity during monthly medication regimen reviews when an as-needed (PRN) psychotropic medication remained ordered beyond	F0756					

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255336		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/20/2026	
NAME OF PROVIDER OR SUPPLIER JONES CO REST HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 683 COUNTY HOME ROAD , ELLISVILLE, Mississippi, 39437			
(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	
F0756 SS = D	Continued from page 28 14 days without documented rationale from the prescribing practitioner supporting continued use or documentation identifying the duration of the continued PRN order for one (1) of six (6) residents reviewed for unnecessary medications. (Resident #104). Findings include: A record review of the facility's policy "Medication Regimen Review (MRR) and Psychotropic Medication Use Policy" with reviewed date 08/06/2026 revealed "... It is the policy of this facility that each resident's medication regimen will be monitored and managed to promote highest function and well-being and is free from unnecessary drugs ... Procedure: ... 3. The MMR includes review of the medical record in order to prevent, identify, report, and resolve medication-related problems, medication errors, or other irregularities ... 6. Any irregularities identified during the MRR will be documented using the MRR Communication Form which will be provided to the physician and the Director of Nursing (DON) within 10 working days of the review ... Unnecessary Drugs and Review of Psychotropic Medication during MRR: ... 5. PRN orders for psychotropic drugs are limited to 14 days, unless the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days. He or she should document their rationale in the resident's medical record and indicate the duration for the PRN order ..." A record review of Resident #104's "Admission Record" revealed the facility initially admitted the resident on 05/07/2013 and readmitted the resident on 09/01/2023 with diagnoses including Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side and Chronic Kidney Disease (CKD). A record review of Resident #104's "Order Summary Report," with active orders as of 08/19/2026, revealed an order dated 04/16/2026 for Lorazepam Oral Concentrate 1 milligram (mg)/0.5 milliliter (mL), give 0.5 mL orally every six hours as needed for anxiety. A record review of Resident #104's Medication Administration Records (MARs) from April through August 2026 revealed PRN Lorazepam was administered on multiple occasions following the 04/16/2026 order, including administrations during May, June, July, and August 2026. A record review of Resident #104's medical record	F0756					

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255336		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/20/2026	
NAME OF PROVIDER OR SUPPLIER JONES CO REST HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 683 COUNTY HOME ROAD , ELLISVILLE, Mississippi, 39437			
(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
F0756 SS = D	Continued from page 29 revealed no documented rationale from the prescribing practitioner supporting continuation of the PRN Lorazepam order beyond 14 days or documentation identifying the duration of the continued PRN order. A record review of the Consultant Pharmacist's Medication Regimen Reviews for Resident #104 revealed the Consultant Pharmacist reviewed the resident's medications and relevant medical record information on 06/17/2026 and 07/13/2026. The reviews documented no medication-related concerns or recommendations regarding the continued PRN Lorazepam order. On 08/19/2026 at 4:15 PM, during an interview, Registered Nurse (RN) #3 stated the Consultant Pharmacist visited the facility monthly and reviewed residents' medical records. On 08/19/2026 at 4:35 PM, during an interview, the Consultant Pharmacist stated she reviewed residents' medication regimens monthly and reported identified findings and recommendations to the Director of Nursing (DON). The Consultant Pharmacist stated she was unaware that PRN orders for psychotropic medications were limited to 14 days unless the prescribing practitioner documented the rationale for extending the order and identified the duration of the extended order. On 08/20/2026 at 3:00 PM, during an interview and review of Resident #104's medical record, the DON stated he was aware of the 14-day limitation for PRN psychotropic medications but believed an exception applied to residents receiving hospice or palliative care. The DON confirmed Resident #104's PRN Lorazepam order was dated 04/16/2026 and the facility could not provide documentation that the prescribing practitioner had documented a rationale for extending the PRN order beyond 14 days or identified the duration of the extended order. The DON further confirmed the Consultant Pharmacist had not identified or reported the continued PRN Lorazepam order as a medication irregularity. On 08/20/2026 at 3:10 PM, during an interview, the Administrator stated she was aware of the requirements governing PRN psychotropic medications, including the 14-day limitation, and expected medication irregularities to be identified and reported.			F0756			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255336		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/20/2026	
NAME OF PROVIDER OR SUPPLIER JONES CO REST HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 683 COUNTY HOME ROAD , ELLISVILLE, Mississippi, 39437			
(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	
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 §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, staff interview, and facility policy review, the facility failed to secure two (2) bottles of medication left unattended on top of a medication cart for one (1) of four (4) days of survey. Findings include: A review of the facility's "Administration and Charting of Medications Policy", reviewed 08/14/2026, revealed, "...Discussion...2. All medications will be stored under lock...if not in view of the nurse..." On 08/17/2026 at 12:02 PM, during an observation of the medication cart on the 400 Hall, (2) bottles of medication were observed unattended on top of the cart while Licensed Practical Nurse (LPN) #1 was inside an unsampled resident's room and did not have the medications within her view. On 08/17/2026 at 12:03 PM, during an interview, Registered Nurse (RN) #1 stated she also observed	F0761					

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255336		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/20/2026	
NAME OF PROVIDER OR SUPPLIER JONES CO REST HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 683 COUNTY HOME ROAD , ELLISVILLE, Mississippi, 39437			
(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	
F0761 SS = D	Continued from page 31 the (2) bottles of medication left unattended on top of the medication cart and placed them inside the cart. RN #1 identified the medications as a laxative and multivitamins and stated LPN #1 was responsible for securing the medications in the cart. RN #1 stated that a resident who accessed and consumed the medications could experience complications. On 08/17/2026 at 12:06 PM, during an interview, LPN #1 stated RN #1 informed her that she had left (2) bottles of medication unattended on top of the medication cart while she was inside a resident's room. LPN #1 stated that a resident could consume improperly secured medications and experience an adverse reaction. On 08/20/2026 at 9:15 AM, during an interview, the Director of Nursing (DON) stated he had been informed that (2) bottles of medication were left unattended on top of the medication cart. The DON stated the facility had residents with dementia who could have taken the medications and experienced complications. The DON stated he expected medications to be locked and secured whenever the nurse walked away from the medication cart.	F0761					
F0880 SS = D	Infection Prevention & Control 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;	F0880					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255336		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/20/2026	
NAME OF PROVIDER OR SUPPLIER JONES CO REST HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 683 COUNTY HOME ROAD , ELLISVILLE, Mississippi, 39437			
(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 32 §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 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, interviews, record review, and	F0880					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255336		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/20/2026	
NAME OF PROVIDER OR SUPPLIER JONES CO REST HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 683 COUNTY HOME ROAD , ELLISVILLE, Mississippi, 39437			
(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 33 facility policy review, the facility failed to implement infection prevention and control practices by failing to use required personal protective equipment (PPE), including gowns, during high-contact care for a resident with a nephrostomy tube who was on Enhanced Barrier Precautions (EBP) for one (1) of (3) residents reviewed for infection control. (Resident #8). Findings include: A review of the facility policy titled, "Enhanced Barrier Precautions", reviewed 6/27/26, revealed, "...Definitions...gown and gloves use during high contact resident care activities...Policy Explanation or Compliance Guidelines...2. Enhanced Barrier Precautions (EBP) will be utilized for residents with any of the following: a...indwelling medical devices...urinary catheters...4. High-contact resident care activities include:...g. Device care use...urinary catheters..." On 08/19/2026 at 2:15 PM, during an observation of nephrostomy-site care for Resident #8, Licensed Practical Nurse (LPN) #7 and a Certified Nursing Assistant (CNA) provided care at the resident's bedside. The CNA assisted with positioning the resident. LPN #7 removed the dressing from the nephrostomy insertion site, cleansed the site with normal saline, and applied a dry dressing. LPN #7 and the CNA wore gloves during the care; however, neither staff member wore the required gown while providing high-contact nephrostomy-site care. On 08/19/2026 at 2:27 PM, during an interview following the observation, LPN #7 confirmed Resident #8 was on Enhanced Barrier Precautions related to the nephrostomy tube. LPN #7 acknowledged that she and the CNA should have worn gowns during the observed nephrostomy-site care because the care involved close contact with the nephrostomy site. On 08/19/2026 at 4:25 PM, during an interview, the Assistant Director of Nursing (ADON) confirmed Resident #8 was on Enhanced Barrier Precautions related to the nephrostomy tube and ESBL. The ADON stated staff were expected to wear appropriate PPE, including a gown and gloves, during direct-contact care. The ADON stated an EBP sign was posted at the resident's room, the resident was identified for staff as requiring precautions, and PPE was available on the hallway. On 08/20/2026 at 11:25 AM, during an interview, the Director of Nursing (DON) confirmed staff should			F0880			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255336		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/20/2026	
NAME OF PROVIDER OR SUPPLIER JONES CO REST HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 683 COUNTY HOME ROAD , ELLISVILLE, Mississippi, 39437			
(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 34 have worn appropriate PPE, including a gown and gloves, while providing Resident #8's nephrostomy-site care. On 08/20/2026 at 12:25 PM, during an interview, the Administrator stated staff were expected to be aware of residents' required precautions and wear appropriate PPE when providing close-contact care. A record review of Resident #8's "Admission Record" revealed the facility admitted the resident on 10/16/2025 with diagnoses including Other Artificial Openings of Urinary Tract Status, Chronic Kidney Disease Stage 2, and Unspecified Hydronephrosis. A record review of Resident #8's "Order Summary Report" revealed an active order for EBP related to the resident's nephrostomy tube. Additional orders directed staff to monitor the nephrostomy tubes for patency and freedom from kinks every shift and monitor the nephrostomy-tube insertion sites for signs of infection, including redness, swelling, warmth, discharge, odor, and leakage every shift. A record review of Resident #8's "Care Plan Report" revealed a focus for Enhanced Barrier Precautions related to the resident's nephrostomy tube and Extended-Spectrum Beta-Lactamase (ESBL), with interventions directing staff to use a gown and gloves during high-contact resident-care activities.			F0880			