

Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/13/2026	
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
M0000	Initial Comments The State Agency (SA) conducted a follow-up revisit at the facility from 10/12/26 through 10/13/26 related to an Annual Recertification Survey with a Complaint Investigation (CI) that was conducted from 8/17/26 through 8/20/26. The SA determined the corrective actions take by the facility removed the deficient practice as of 09/29/26. However, the facility remained out of compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements until 09/30/26, the compliance date for Life Safety Code. The SA recommends the facility be placed back in compliance effective 9/30/26.			M0000			

Office of Primary Care and Health Systems Management

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