STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255336	A. Building B. Wing	05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jones CO Rest Home	683 County Home Road Ellisville, MS 39437

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observation, record review, facility investigation review, and facility policy review, the facility failed to provide adequate supervision to prevent Resident #1 and Resident #2 from eloping from the facility on 5/18/26 at 5:41 PM. The facility staff did not know that Resident #1 and Resident #2 were out of the facility on the facility grounds for 11 minutes. This concern was identified for two (2) of eight (8) residents reviewed for diagnoses of Alzheimer's disease and dementia (Resident #1 and Resident #2). The facility's failure to provide adequate supervision resulted in Resident #1 and Resident #2 leaving the facility unsupervised, placing these residents and other residents with diagnoses of Alzheimer's disease and dementia at risk for elopement and the likelihood of serious injury, harm, impairment, or death. The situation was determined to be Immediate Jeopardy (IJ) that began on 5/18/26 when Resident #1 and Resident #2 exited from the facility unattended and unsupervised. The facility Administrator was notified of the IJ and SQC on 5/26/26 at 3:20 PM and was presented with the IJ template.The facility provided an acceptable Corrective Action Plan on 5/27/26, in which they alleged all corrective actions to remove the IJ were completed on 5/19/26 and the IJ removed on 5/20/26, prior to SA entrance on 5/26/26. Based on the facility's implementation of corrective actions on 5/19/26, the SA determined the IJ and SQC to be Past Non-Compliance (PNC). Findings include: A review of the facility's policy, Elopement/Missing Resident Policy, reviewed date: 5/19/2026, revealed, Purpose: To ensure residents who exhibit unsafe wandering behavior and/or who are at risk for elopement receive preventative measure, adequate supervision.Definition: Elopement occurs when a resident leaves the premises or a safe area without authorization or supervision . A review of the facility's policy, FALLS ACCIDENTS AND INCIDENTS POLICY, reviewed date: 5/8/26, revealed, Purpose: To promote an environment as free as is possible, of accident hazards over which the facility has control. Scope: Staff to provide adequate supervision and assistive devices to help prevent avoidable accidents and injury. Responsibilities: All staff are to be involved in observing and identifying potential hazards in the environment, while taking into consideration the unique characteristics and abilities of each resident . A record review of the facility investigation revealed on 5/18/26 at approximately 5:41 PM, a transportation service employee who was not employed with the facility exited the facility through the front door using his badge for access. Resident #1 and Resident #2 followed him outside prior to the front door entrance closing. At approximately 5:52 PM, according to video surveillance, a dietary aide observed both residents in the parking lot. He immediately returned to the facility and notified a Registered Nurse. At the same time, another resident's family member was driving into the parking (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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