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 _____	10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JONES CO REST HOME	683 COUNTY HOME ROAD ELLISVILLE, MS 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
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 10/23/2023 through 10/26/2023. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F565, F623, F625, F640, F812 and F880. The facility had a census of 118 and was licensed for 122 beds.	F 000		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every	F 565		12/6/23

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

Electronically Signed | 11/15/2023

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 _____	10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JONES CO REST HOME	683 COUNTY HOME ROAD ELLISVILLE, MS 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
F 565	Continued From page 1 request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and facility policy review the facility failed to ensure grievances related to dietary services were resolved for ten (10) of 24 sampled residents. (Resident #1, #18, #22, #42, #58, #61, #67, #94, #96 and #104) Findings include: Review of the facility's, "Grievance Policy" revised 06/23/23 revealed, " ...To ensure the resident, our resident representatives right, to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without the fear of discrimination or reprisal ...Responsibilities ...The facility will review grievances in a timely manner and must make prompt efforts to resolve grievances ...Procedure ...4. Grievances may be voiced orally to the department manager, to the Grievance Official, during resident council ...8. Any immediate action needed to prevent further violations of any residents' rights will be taken ...10. The grievance official will take steps to resolve the grievance and record information about the grievance and those actions on the grievance form. 11. Steps to resolve the grievance may involve discussion with	F 565	F565 (1) A one-on-one in-service was conducted on 11/15/23, by the Administrator and the Director of Nurses (DON) with the Social worker regarding the facility practices for recording grievances and follow-up actions required if grievances are voiced. The Administrator and the Social Worker met with Resident #1,#18,#22,#42,#58,#61,#67, #94,#96,and #104 on 11/15/23, to provide information about actions taken by the facility to resolve the grievances related to dietary services voiced in resident council meetings. Facility actions taken to resolve the grievances were discussed by the Social Worker and Administrator in a Resident Council Meeting held on 11/15/23. A summary of the grievances and the resolution were recorded on the facility grievance form. (2) All residents have the potential to be affected by failure to ensure grievances are resolved.	

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 _____	10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JONES CO REST HOME	683 COUNTY HOME ROAD ELLISVILLE, MS 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
F 565	Continued From page 2 the appropriate department manager for follow up ..." A record review of the "Resident Council Meeting", dated 4/25/23 revealed a representative of the food service company was in attendance and food seasoning was discussed. A record review of the "Resident Council Meeting", dated 5/30/23 revealed a resident concern regarding green beans "tastes as if they are out of the can". A record review of the "Resident Council Meeting", dated 6/27/23 revealed that the DM was not in attendance, but residents verbalized a food concern that "peanuts were not cooked long enough". Record review of the "Resident Council Meeting", dated 7/25/23, 8/29/23, and 9/26/23, revealed the Dietary Manager (DM) was in attendance. Residents voiced multiple food concerns. During a meeting with the Resident council members on 10/24/23 at 03:00 PM, the residents complained the food was cold and had not tasted good since the new dietary company had taken over for the facility. The residents said they had invited the Dietary Manager (DM) to attend their meetings each month to discuss their dietary concerns, but nothing had changed regarding the taste of the food, because the food was bland and had no flavor. During an interview on 10/25/23 at 12:50 PM, with the DM, she explained that the dietary staff could not add seasonings to the food recipe. She confirmed she had been invited to attend resident	F 565	(3) On 11/14/23, the Quality Assurance and Assessment (QAA) Committee reviewed the Resident Council Meetings policy and the Grievance policy and approved with no changes. The Grievance Form was reviewed and no changes recommended by QAA. The Grievance log was reviewed and the QAA Committee recommended revisions to include an area to document that the form was reviewed by the Quality Assurance Committee. Changes were made to the Grievance log at that time. (4) Beginning 11/14/23, all grievances will be documented on the facility Grievance Form by the Grievance Official (Social Worker or Administrator). Grievances will be communicated to other department managers as appropriate and discussed in the daily Quality Assurance meeting to ensure follow-up and steps are taken for resolution. Corrective action will be taken at the time for issues identified. The Grievance Official will keep the resident, or resident representative appropriately apprised of its progress toward resolution. This process will continue indefinitely. The Grievance Log will be reviewed by the Quality Assurance (QA) Committee in the monthly meeting, beginning 12/5/23, to verify that all recorded grievances were investigated appropriately and acted upon. Corrective action will be taken at the time for issues identified. The Quality Assurance Committee will make any	

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 _____	10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JONES CO REST HOME	683 COUNTY HOME ROAD ELLISVILLE, MS 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
F 565	Continued From page 3 council meetings every month and tried to assist with the resident's requests, but the Registered Dietician (RD) made the decisions regarding seasoning changes for the recipes and would not allow the DM to alter the recipes. She stated that the facility had residents that had orders for bland diets and that the residents could add salt or pepper from the packets on their meal trays. During an interview on 10/25/23 at 1:00 PM, with the Social Worker (SW), she reported that she records the minutes of the Resident Council meetings. She confirmed that the residents had complained about the taste and temperature of the food. The SW confirmed she failed to document the food complaints on the council meeting minutes if the DM was present for the meeting and discussed the concerns with the residents. The SW also stated that the residents' food concerns had been discussed in daily stand-up (communication) meetings during the past several months. During an interview on 10/25/23 at 1:20 PM, with the Director of Nursing (DON), he confirmed the residents have complained for several months of the food being cold and not having a good taste. The DON confirmed that the DM was attending monthly resident council meetings and he thought she was working to correct the residents' concerns. The DON confirmed that the food concerns had been discussed in stand-up meetings. During an interview on 10/26/23 at 09:00 AM, with the Administrator, she confirmed the residents had complained about the food being served cold and did not taste good, since the new company had began at the facility. The Administrator	F 565	recommendations or changes if needed to ensure compliance. This process will continue indefinitely.	

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 _____	10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JONES CO REST HOME	683 COUNTY HOME ROAD ELLISVILLE, MS 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
F 565	Continued From page 4	F 565		

explained that the new company had been at the facility for one year and she was giving them time to correct the residents' concerns. She confirmed the concerns had been discussed in stand-up meetings and with the DM, RD and corporate team.

During an interview on 10/26/23 at 10:10 AM, with the RD, he confirmed that the resident had complained about the taste of the food and that the food was served cold. He explained that he was allowing the dietary service to work out the residents' concerns and he had encouraged the DM to use salt or other spices to make the food savory. The RD reported that there was only one (1) resident who received a bland diet.

Resident #1

A record Review of the "Transfer/Discharge Report" revealed the facility admitted Resident #1 on 03/07/23 with a diagnosis of Cerebral Palsy.

A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/1/23 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated she was cognitively Intact.

Resident #18

A record Review of the "Transfer/Discharge Report" revealed the facility admitted Resident #18 on 09/03/23 with a diagnosis of Cerebral Infarction.

A record review of the Quarterly MDS with an ARD of 9/6/23 revealed Resident #18 had a BIMS score of 15, which indicated she was cognitively

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 _____	10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JONES CO REST HOME	683 COUNTY HOME ROAD ELLISVILLE, MS 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
F 565	Continued From page 5	F 565		

intact.

Resident #22

A record Review of the "Transfer/Discharge Report" revealed the facility admitted Resident #22 on 08/6/23 with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD).

A record review of the Quarterly MDS with an ARD of 8/24/23 revealed Resident #22 had a BIMS score of 15, which indicated Resident #22 was cognitively intact.

Resident #42

A record Review of the "Transfer/Discharge Report" revealed the facility admitted Resident #42 on 01/11/22 with a diagnosis of Hypertension.

A record review of the Quarterly MDS with an ARD of 9/4/23 revealed Resident #42 had a BIMS score of 15, which indicated she was cognitively intact.

Resident #58

A record Review of the "Transfer/Discharge Report" revealed the facility admitted Resident #58 on 04/14/23 with a diagnosis of Bipolar Disorder.

A record review of the Minimum Data Set (MDS) with an ARD of 10/17/23 revealed Resident #58 had a BIMS score of 15, which indicated she was cognitively Intact.

Resident #61

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 _____	10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JONES CO REST HOME	683 COUNTY HOME ROAD ELLISVILLE, MS 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
F 565	Continued From page 6	F 565		

A record Review of the "Transfer/Discharge Report" revealed the facility admitted Resident #61 on 02/10/23 with a diagnosis of COPD.

A record review of the Quarterly MDS with an ARD of 8/3/23 revealed Resident #61 had BIMS score of 15, which indicated she was cognitively intact.

Resident #67

A record Review of the "Transfer/Discharge Report" revealed the facility admitted Resident #67 on 09/05/23 with a diagnosis of Diabetes Mellitus.

A record review of the Quarterly MDS with an ARD of 9/20/2023 revealed Resident #67 had a BIMS score of 14, which indicated she was cognitively Intact.

Resident #94

A record Review of the "Transfer/Discharge Report" revealed the facility admitted Resident #94 on 03/18/23 with a diagnosis of COPD.

A record review of the MDS with an ARD of 10/10/23 revealed Resident #94 had BIMS score of 12, which indicated her cognition was moderately impaired.

Resident #96

A record Review of the "Transfer/Discharge Report" revealed the facility admitted Resident #96 on 05/29/23 with a diagnosis of Aneurysm.

A record review of the Quarterly Minimum Data

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 _____	10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JONES CO REST HOME	683 COUNTY HOME ROAD ELLISVILLE, MS 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
F 565	Continued From page 7 Set (MDS) with Assessment Reference Date (ARD) 9/26/23 revealed Resident #96 had a BIMS score of 15, which indicates resident is cognitively Intact. Resident #104 A record Review of the "Transfer/Discharge Report" revealed the facility admitted Resident #104 on 05/08/23 with a diagnosis of Chronic Kidney Disease. A record review of the Quarterly MDS with an ARD of 9/21/23 revealed Resident #104 had a BIMS score of 13, which indicated she was cognitively intact.	F 565		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §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 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	F 623		12/6/23

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 _____	10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JONES CO REST HOME	683 COUNTY HOME ROAD ELLISVILLE, MS 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
F 623	Continued From page 8	F 623		

(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, 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;

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 _____	10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JONES CO REST HOME	683 COUNTY HOME ROAD ELLISVILLE, MS 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
F 623	Continued From page 9 (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). This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to provide written notification of transfer to the resident and the	F 623	F623 (1) For dates of transfer on 9/18/23, and 9/28/23, Resident #65 was provided the	

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 _____	10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JONES CO REST HOME	683 COUNTY HOME ROAD ELLISVILLE, MS 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
F 623	Continued From page 10 Resident's Representative (RR), for a resident transferred to the hospital for one (1) of two (2) resident records reviewed for hospitalizations. Resident #65 Findings include: Record Review of the facility's policy, "Resident Transfer and Discharge Policy," with a revision date of 3/11/22, revealed, " ... 7. Emergency Transfers/Discharges initiated by the facility for medical reasons.... e. Complete and send the following forms at the time of transfer: i. Notice of Bed Hold for the resident representative ii. Notice of transfer for the resident representative ..." At 12:35 PM on 10/23/23, in an interview with Resident #65, she revealed she had been admitted to the hospital several times due to tremors and pneumonia. She stated she was not given anything in writing from the facility at the time of her transfers to the hospital. A record review of the "Physician Order Sheet," for Resident #65, revealed there was an order dated 9/18/23, to send the resident to the ER (Emergency Room) related to respiratory distress. There was another physician order dated 9/28/23, to send the resident to the ER for SOB (shortness of breath). The Licensed Social Worker (LSW) revealed on 10/23/23 at 3:29 PM, in an interview, when a resident is sent to the hospital, the nurse fills out the transfer letter. She stated once the nurse fills out the letter, it is given to her, she calls the family, and gives the letter to the Administrator Assistant (AA) or Business Office Coordinator (BOC) to mail. The LSW added that they mail the	F 623	reason for transfer/discharge in writing by Social Services staff on 11/15/23, and understanding was verified and documented. The resident representative was also notified and given a copy of the notice. (2) The facility has determined that all residents who have been transferred or discharged have the potential to be affected. (3) On 11/14/23, the Quality Assurance and Assessment (QAA) Committee met and reviewed the Resident Transfer and Discharge policy and approved with no changes. The Notice of Resident Transfer or Discharge form was reviewed in the meeting. Revisions to the process for completion of the Notice of Resident Transfer or Discharge form were recommended. The Notice of Resident Transfer or Discharge will be completed in the Electronic Medical Record (EMR) by the Registered Nurse (RN) or Licensed Practical Nurse (LPN) transferring the resident. The Notice of Bed Hold for the resident representative is included in the Notice of Resident Transfer or Discharge. The Registered Nurse (RN) or Licensed Practical Nurse (LPN) will provide a copy of the Notice of Resident Transfer or Discharge to the resident at the time of the transfer. In-services began on 11/15/23, by the Director of Nursing and Administrator with all Registered Nurses (RNs), Licensed Practical Nurses (LPNs),Social services (SS) staff, and the Business Office Coordinator to review the	

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 _____	10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JONES CO REST HOME	683 COUNTY HOME ROAD ELLISVILLE, MS 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
F 623	Continued From page 11 original letters and keep a copy for their records. The LSW stated this is done every time a resident is sent out to a hospital. The LSW reported on 10/24/23 at 11:39 AM, in an interview, that she looked for hospital transfer letters for September. However, she stated she could not find them. She stated once she forwards the letters to the AA or BOC, she usually makes a copy and documents to whom she gave the letters to mail. She revealed that without a copy of the letters and a notation regarding their disposition, she could not remember who or when she gave them to and cannot recall if she did that for the September letters at all. In an interview on 10/24/23 at 11:40 AM, with the BOC, she revealed if she was given the original copies, she would have mailed the original to the RR and placed a copy in a binder. However, she stated she could not recall the letters being given to her to be mailed. She stated the LSW is supposed to give the letters to her or the AA to be mailed to the RR, however, she confirmed there were no copies of letters for September in the binder. During an interview on 10/24/23 at 12:05 PM, in an interview with the AA, she revealed the facility keeps a copy of the original letters in a binder. She stated there are no letters in the binder for September, she does not have the letters, and no one gave her letters for September. In an interview on 10/25/23 at 2:35 PM, the Administrator revealed she was made aware of the letters not being done. She stated she expects staff to follow the facility's policy related to resident transfers.	F 623	Resident Transfer and Discharge policy, and addressing the circumstances regarding required notices for residents upon transfer and discharge from the facility, and required documentation. In-services will continue until all LPNs, RNs, SS, and the Business Office Coordinator have been in-serviced. In-services will be completed by 12/5/23. New staff hired to these positions will be in-serviced upon hire. (4) Beginning 11/14/23, for a period of eight (8) weeks the Business Office Coordinator (BOC) or the Administrator will conduct a record audit of all residents who have been transferred or discharged from the facility to ensure the record includes a completed copy of the transfer/discharge notice. Corrective action will be taken at the time if issues are identified. Audit reports will be reviewed by the Quality Assurance Committee monthly beginning 12/5/23, until such time substantial compliance has been achieved as determined by the committee. The Quality Assurance Committee will make any recommendations or changes if needed to ensure compliance.	

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 _____	10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JONES CO REST HOME	683 COUNTY HOME ROAD ELLISVILLE, MS 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
F 623	Continued From page 12 Record review of Resident #65's "Transfer/Discharge Report," revealed a readmit date of 7/19/23, with diagnoses of Chronic Obstructive Pulmonary Disease, Acute and Chronic Respiratory Failure, and Essential Tremors. Record review of Resident #65's Discharge Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 9/13/2023, as well as the Discharge MDS with an ARD of 9/28/23, revealed the resident was discharged to an acute care hospital. Record review of Annual MDS with ARD 6/19/23 revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. Record review of "Progress Notes" revealed Resident #65 was transferred to an acute care hospital on 9/13/23, related to low O2 Sats (oxygen saturation) levels ranging from 56%-84%. "Progress Notes, dated "9/28/23, revealed Resident #65 was again transferred to an acute care hospital related to cyanosis (bluish discoloration) and inability to respond to commands.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §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 facility must provide written information to the resident or resident representative that specifies-	F 625		12/6/23

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 _____	10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JONES CO REST HOME	683 COUNTY HOME ROAD ELLISVILLE, MS 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
F 625	Continued From page 13 (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. This REQUIREMENT is not met as evidenced by: Based on interviews, record review and facility policy review, the facility failed to provide the Resident and the Resident Representative (RR) with written notification of the bed hold policy at the time of transfer to the hospital for one (1) of two (2) residents reviewed for hospitalizations. Resident #65 Findings include: Record Review of the facility's policy, "Notice of Bed Hold and Return Policy," with a revision date of 1/9/20, revealed, "It is the policy of this facility to provide written information to the resident and/or the resident representative regarding bed hold policies prior to and upon transferring a resident to the hospital ..."	F 625	F625 (1) For dates of transfer on 9/18/23 and 9/28/23, Resident #65 was provided written notice which specifies the duration of the bed-hold policy by Social Services staff on 11/14/23 and understanding was verified and documented. The resident representative was also notified and given a copy of the notice provided by Social Services. (2) The facility has determined that all residents who have been transferred or discharged have the potential to be affected. (3) On 11/14/23, the Quality Assurance	

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 _____	10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JONES CO REST HOME	683 COUNTY HOME ROAD ELLISVILLE, MS 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
F 625	Continued From page 14 On 10/23/23 at 12:35 PM, in an interview with Resident #65, she revealed she had been admitted to the local hospital several times due to tremors and pneumonia. She stated at the time of her hospitalizations, she had not received anything in writing from the facility regarding their bed hold policy. A record review of the "Physician Order Sheet," for Resident #65, revealed there an order dated 9/18/23, to send the resident to the ER (Emergency Room) related to respiratory distress. On 9/28/23, there was another physician order to send the resident to the ER for SOB (shortness of breath). On 10/23/23 at 3:29 PM, in an interview the License Social Worker (LSW) revealed when a resident is sent to the hospital, the nurse fills out the bed hold letter and gives it to her. She then calls the family and gives the letters to the Administrator Assistant (AA) or Business Office Coordinator (BOC) to mail. She stated the original letters are kept in a binder in the front office. She further commented, this is done every time a resident transferred to an acute care hospital. On 10/24/23 at 11:39 AM, in an interview with the LSW, she revealed she had looked for the bed hold letters for September and could not find them. She stated she usually keeps a copy, with a notation of who she had given the letters to mail. However, she could not find letters for the month of September, and she could not recall if she did that for the month of September. On 10/24/23 at 11:40 AM in an interview with BOC, she revealed if she had been given the bed	F 625	and Assessment Committee met and reviewed the Notice of Bed Hold and Return policy and recommended revisions. The Notice of Bed Hold and Return policy was revised to include Admissions Coordinator providing written information concerning the facility bed-hold policy and the Business Office Coordinator to contact the resident/representative to verify the notice of bed hold was received. In-services began on 11/15/23 by the Director of Nursing and Administrator with all Registered Nurses (RNs), Licensed Practical Nurses (LPNs), Social Services (SS) staff, and the Business Office Coordinator to review the Notice of Bed Hold and Return policy, and addressing the circumstances regarding required notices and documentation for residents upon transfer and discharge form the facility. In-services will continue until all LPNs, RNs, SS, and the Business Office Coordinator have been in-serviced. In-services will be complete on 12/5/23. New staff hired to the positions will be in-serviced upon hire. (4) Beginning 11/14/23, for a period of eight weeks, the Administrator or the Business Office Coordinator (BOC) will conduct a record audit of all residents who have been transferred or discharged from the facility to ensure the record includes a completed copy of the Bed Hold policy notice. Corrective action will be taken at the time if issues are identified. Audit reports will be reviewed by the Quality Assurance Committee monthly, beginning	

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 _____	10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JONES CO REST HOME	683 COUNTY HOME ROAD ELLISVILLE, MS 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
F 625	Continued From page 15 hold letters for the month of September, she would have mailed the original to the Resident Representative (RR) and kept a copy to place in the binder in the front office. The BOC confirmed there were no bed hold letters in the binder for the month of September. On 10/24/23 at 12:05 PM, in an interview with the AA, she revealed after bed hold letters are mailed, they put a copy of the original in the binder. She confirmed there are no bed hold letters in the binder for the month of September. She stated no one gave her the letters. On 10/25/23 at 2:35 PM, in an interview with the Administrator, she acknowledged she was made aware of the letters not being done. She stated she expects staff to follow the facility's policy related to transfers and discharges regarding bed holds. Record review of Transfer/Discharge Report for Resident #65 revealed a readmit date of 07/19/23 with diagnoses of Chronic Obstructive Pulmonary Disease, Acute and Chronic Respiratory Failure, and Essential Tremors. Record review of Resident #65's Discharge Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 9/13/2023, as well as the Discharge MDS, with an ARD date of 9/28/23, revealed the resident was discharged to an acute care hospital. Record review of Annual MDS with ARD 6/19/23 revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated resident was cognitively intact. Record review of the facility's "Progress Notes" revealed Resident #65 was transferred to an	F 625	on 12/5/23, until such time substantial compliance has been achieved as determined by the committee. The QA Committee will make any recommendations or changes if needed to ensure compliance.	

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 _____	10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JONES CO REST HOME	683 COUNTY HOME ROAD ELLISVILLE, MS 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
F 625	Continued From page 16 acute care hospital on 9/13/23, related to low O2 Sats (oxygen saturation) levels ranging from 56%-84%. "Progress Notes" dated 9/28/23, revealed Resident #65 was again transferred to an acute hospital, related to cyanosis (bluish discoloration) and inability to respond to commands.	F 625		
F 640 SS=B	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to	F 640		12/6/23

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 _____	10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JONES CO REST HOME	683 COUNTY HOME ROAD ELLISVILLE, MS 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
F 640	Continued From page 17 the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to transmit a discharge Minimum Data Set (MDS) Assessment for one (1) of 24 residents reviewed for MDS assessments. (Resident #78) Findings Include: Review of facility's, "MDS (Minimum Data Set), CAA (Care Area Assessment), and Care Plan Documentation Policy", revised 10/18/2019, revealed, " ...It is the policy of this facility to provide documentation in the medical record for MDS, CAA, and care plan purposes ..." Record review of the "Transfer/Discharge Report" revealed the facility admitted Resident #78 on 6/5/23 with a diagnosis of Alzheimer's Disease.	F 640	F640 (1) The Minimum Data Set (MDS) for Resident #78 was transmitted on 10/25/23. On 10/25/23, an in-service was conducted by the Director of Nurses with MDS nurses regarding timely submission of MDS. (2) All residents have the potential to be affected by failing to transmit MDS. (3) On 11/14/23, the Quality Assurance and Assessment (QAA) Committee met and reviewed the MDS, Care Area Assessment (CAA), and Care Plan policy with revisions made at that time to include transmission requirements for MDSs based on the QAA Committee	

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 _____	10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JONES CO REST HOME	683 COUNTY HOME ROAD ELLISVILLE, MS 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
F 640	Continued From page 18 Record review of the "Progress Notes" revealed a "Discharge Summary" note, dated 7/2/23 at 12:30 (PM), for Resident #78 for " ...1230 (12:30 PM) Coroner called to pronounce death ..." Review of the medical record revealed Resident #78 had a" Death in Facility" MDS with an ARD of 7/2/23 completed and signed on 7/3/23. Review of the MDS submission report revealed the "Submission Date/Time" was 10/25/23 at 16:24 (4:24 PM) and the Discharge MDS for Resident #78 that was completed on 7/3/23 was not transmitted until 10/25/23, which was more than 14 days. During an interview on 10/25/23 at 03:11 PM, with Licensed Practical Nurse (LPN) #2, she acknowledged that she failed to submit the MDS for the death in the facility for Resident #78 in a timely manner. LPN #2 stated that she checked the wrong box when completing the MDS and chose "do not submit" in error. She confirmed that the MDS was completed but was not transmitted. During an interview on 10/25/23 at 03:54 PM, with the Director of Nursing (DON), he stated that he had not reviewed the MDS, but he expected the nurses to submit the MDS in a timely manner.	F 640	recommendations. (4) The MDS Nurse will perform an audit each week, beginning 11/15/23, to ensure that all completed MDS' are transmitted according to facility policy. Corrective action will be taken at the time if issues are identified. This audit will continue indefinitely. Audit reports will be reviewed by the Quality Assurance Committee monthly, beginning 12/5/23, until substantial such time substantial compliance has been achieved as determined by the committee. The Quality Assurance Committee will make any recommendations or changes if needed to ensure compliance.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources	F 812		12/6/23

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 _____	10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JONES CO REST HOME	683 COUNTY HOME ROAD ELLISVILLE, MS 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
F 812	Continued From page 19 approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and facility policy review, the facility failed to store food in accordance with professional standards for food service safety related to food items not dated with a use-by date, food items not discarded by the use-by date, spoiled foods not discarded, food items without an identifying label, food items improperly stored, and food items opened and not sealed for one (1) of three (3) kitchen observations and had the potential to affect all residents who receive food items from the kitchen. Findings Include: A review of the facility's policy, "Food and Supply Storage", revised 1/22, revealed, "... All food ...shall be stored in such a manner as to prevent contamination ...Procedures ...Cover, label and date unused portions and open packages ...Discard food past the use-by or expiration date ...Dry Storage ...Foods that must be opened must	F 812	F812 (1) The Dietary Manager discarded the expired, opened, undated, unlabeled and any expired foods on 10/23/23. (2) All residents have the potential to be affected by not discarding expired, opened, undated, unlabeled foods. (3) On 11/14/23, the Quality Assurance and Assessment Committee met and revised the food safety policy. On 10/24/23, the Dietary Manager conducted verbal education to all Food Service staff present regarding food safety practices. On 11/15/23, the Dietary Manager conducted a formal in-service for all Food Service staff regarding the revised policy and food safety practices including, but not limited to, proper food scoop storage, properly dating food items with a use by date, discarding food items by the use-by	

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 _____	10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JONES CO REST HOME	683 COUNTY HOME ROAD ELLISVILLE, MS 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
F 812	Continued From page 20 be store in ...approved containers that have tight-fitting lids ...Hang scoop. Scoops may be stored in bins on a scoop holder ...Refrigerated Stored ... ...sort produce daily to remove spoiled pieces ..." On 10/23/23 at 11:45 AM, during an observation and interview of the kitchen with the Chef revealed the following: 1. An observation of the dry storage bins revealed a scoop that was not stored in the designated holder and was lying on top of the sugar. 2. An observation of the contents of Refrigerator #1 revealed one (1) opened carton of prune juice that had a "date opened" label of 10/4/23 and indicated the juice was good through 10/7/23. There were two (2) opened cartons of thickened orange juice and one (1) opened carton of thickened dairy beverage with no label indicating the use-by date. 3. An observation of Refrigerator #2 revealed one (1) unopened ham with no label indicating the use-by date or a manufacturer's expiration date. There were two (2) containers of strawberries covered with white biological growth. There were three (3) 10-pound packages of meat with no identifying label and no use-by date. The Chef stated the meat was ground beef. There was one (1) sheet pan of rolls with no use-by date. 4. An observation of the Freezer revealed one (1) opened bag of French fries with no use-by date on the package. 5. An observation of the dry food storage area	F 812	date, discarding food items by the use-by date, monitoring for and discarding spoiled foods, identifying food items with labeling, properly storing food items, properly storing and sealing opened food items. The contract with the current Food Services provider will terminate on 11/30/23, and all newly hired staff will be in-serviced on hire. (4) Beginning on 11/15/23, the Dietary Manager or Assistant Dietary Manager will conduct weekly audits to identify food safety issues. Corrective Action will be taken at the time for any issues identified. These audits will continue for eight (8) weeks. The Registered Dietician will complete sanitation and food safety audits monthly, beginning 12/4/23. Corrective action will be taken at the time for any issues identified. Audit reports will be reviewed by the Quality Assurance Committee monthly, beginning 12/5/23, until such time substantial compliance has been achieved as determined by the committee. The Quality Assurance Committee will make any recommendations or changes if needed to ensure compliance.	

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 _____	10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JONES CO REST HOME	683 COUNTY HOME ROAD ELLISVILLE, MS 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
F 812	Continued From page 21 revealed one (1) opened bottle of lemon juice with a manufacturer's label that indicated "refrigerate after opening." There was one (1) opened plastic bag of corn starch, which was unsealed, and the product was visible. There was one (1) box of quick creamy wheat, the top flap of the box was opened, unsealed, and the product was visible. The Chef stated in an interview during the tour that he would discard the expired, opened, undated, unlabeled items and any expired foods. On 10/25/23, at 10:12 AM, an interview with the Dietary Manager (DM), revealed her expectation is that expired foods be discarded, the dry food storage items be securely sealed and properly stored. The DM acknowledged that the food items could cause the residents to get sick. The DM stated the scoop being left on top of the sugar and the strawberries covered in white biological growth were unacceptable. On 10/26/23 at 09:34 AM, in an interview with the Administrator, she confirmed that her expectation was that food should be labeled and monitored daily for expiration dates.	F 812		
F 880 SS=E	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	F 880		12/6/23

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 _____	10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JONES CO REST HOME	683 COUNTY HOME ROAD ELLISVILLE, MS 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
F 880	Continued From page 22	F 880		

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 §483.70(e) and following accepted national standards;

§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

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 _____	10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JONES CO REST HOME	683 COUNTY HOME ROAD ELLISVILLE, MS 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
F 880	Continued From page 23 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, staff interviews, record review, and facility policy review, the facility failed to ensure staff washed or sanitized hands during Percutaneous Endoscopic Gastrostomy (PEG) site care for one (1) of two (2) residents reviewed with PEG tubes. Resident # 38 Findings Include: Review of the facility's policy, "Infection Prevention and Control Program Policy, revised 8/22/2019, revealed, "Purpose: To 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 ..." During PEG site care, on 10/24/23 at 10:20 AM, for Resident # 38, Licensed Practical Nurse (LPN) #1 did not wash or sanitize her hands or	F 880	F880 (1) For Resident #38, one on one verbal education was conducted on 10/25/23, with Licensed Practical Nurse (LPN) #1 regarding the facility Infection Prevention and Control Program policy and standards of practice for proper hand hygiene and glove changes while performing treatments, including during peg site care. This education was provided by the Director of Nurses (DON). A one on one in-service was conducted on 11/14/23, with Licensed Practical Nurse (LPN) #1 regarding the facility Infection Prevention and Control Program policy and standards of practice for proper hand hygiene and glove changes while performing treatments, including during peg site care. This education was provided by the Quality Assurance Infection Preventionist (QA-IP). On 11/14/23, LPN #1	

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 _____	10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JONES CO REST HOME	683 COUNTY HOME ROAD ELLISVILLE, MS 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
F 880	Continued From page 24 change her gloves after removing the soiled dressing from the PEG site. She used the same gloves to clean the site. LPN #1 also did not wash or sanitize her hands before she donned a clean pair of gloves and applied the treatment to the PEG site. On 10/25/23 at 02:38 PM, in an interview with LPN #1, she confirmed that she should have discarded her gloves after she had removed the soiled dressing from the PEG site. She stated she should have washed or sanitized her hands before and applied clean gloves prior to cleaning the PEG site and before she applied a clean dressing. She explained that her actions could have led to the resident acquiring an infection. Record review of the "Transfer and Discharge Report" revealed the facility admitted Resident #38 on 6/15/23 with diagnosis of Adult Failure to Thrive and Dysphagia. Record review of the "Order Listing Report" revealed Resident #38 had a Physician's Order with an order date of 01/23/2023 to "Clean peg site with normal saline, pat dry, apply hydrophilic foam under peg bumper daily ..." On 10/26/23 at 09:45 AM, in an interview with the Director of Nursing (DON), he stated that LPN #1 should have performed hand hygiene after removing the soiled dressing, applied clean gloves, and then cleaned the PEG site. She should have performed hand hygiene after touching the dressing and between gloves changes. She should have changed gloves after touching the bed remote. The DON stated there is a good possibility that her actions could cause the resident to get an infection.	F 880	demonstrated competency for hand hygiene, glove changes, and infection prevention and control procedures during treatment verified by the QA-IP through return demonstration. (2) All residents have the potential to be affected by improper hand hygiene and glove changes while performing treatments, including peg site care. (3) On 11/14/23, the Quality Assurance and Assessment (QAA) Committee met and reviewed the Infection Prevention and Control (IPC) policy and the Gastrostomy Tube Proper Cleaning Technique policy. No recommendations were made to revise the IPC policy. The QAA Committee recommended revisions to the Gastrostomy Tube Proper Cleaning Technique policy to include care of peg sites requiring medications performed by competent licensed nurse. The policy was revised and a competency checklist tool for peg site care was developed by QAA at that time. In-services began on 11/15/23, by the QA-IP and the DON with all Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) to review the Infection Prevention and Control policy and the Gastrostomy Tube Proper Cleaning Technique policies. In-services will continue until all LPNs and RNs have been in-serviced. After education and training, competency will be verified through return demonstration and documented by the QA-IP, DON, or the Wound Nurse. New RNs and LPNs will be	

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 _____	10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JONES CO REST HOME	683 COUNTY HOME ROAD ELLISVILLE, MS 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
F 880	Continued From page 25 On 10/26/23 at 10:07 AM, in an interview with Registered Nurse #1 (RN)/Infection Preventionist, she confirmed LPN #1 should have performed hand hygiene between glove changes and should have discarded her gloves after removing and discarding the soiled dressing because of infection control issues.	F 880	in-serviced and competency verified by the QA-IP, DON, or the Wound Nurse upon hire. (4) The QA-IP, DON, or the Wound Nurse will conduct three audits two times weekly for 8 weeks beginning 11/15/23, to verify proper infection control procedures are followed during resident treatments according to standards of practice and facility policy. Corrective actions will be taken at the time for issues identified. Audit reports will be reviewed by the Quality Assurance Committee monthly, beginning 12/5/23. The Quality Assurance and Assessment Committee will make any recommendations and/or changes if needed to ensure compliance.	