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 **05/27/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JONES CO REST HOME	**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 Complaint Investigation (CI MS #3018500) a Facility Reported Incident (FRI), at the facility from 5/26/26 through 5/27/26 related to an elopement. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements. The facility failed to provide adequate supervision to prevent Resident #1 and Resident #2 elopement from the facility on 5/18/26 at approximately 5:41 PM. Resident #1 and Resident #2 were away from the facility and unsupervised for approximately 11 minutes. The facility staff were unaware of Resident #1 and Resident #2 absence until a dietary aide observed both resident's walking in the facility parking lot. As the dietary aide was attempting to leave the facility in his car, he noticed the residents in the parking lot, then he went back into the facility to report the residents in the parking lot and notified the charge nurse. Both residents were located at approximately 5:42 PM, approximately 90 feet from the front entrance, observed was an open concrete driveway/entrance loop bordered by low curved concrete retaining walls with landscaped grassy areas and trees on each side. The driveway was wide, unobstructed, and led from the covered front entrance toward the outer drive/roadway area. The area was exposed to vehicle traffic; they were in the parking lot of the facility. The facility's immediate investigation revealed that Resident #1 and Resident #2 exited the facility through the front door of the facility, following a transport driver who was not employed by the facility. Resident #1 and Resident #2 were immediately escorted back into the facility without concerns. During the investigation, the SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 5/18/26 and existed at: Rule 45.21.8 Accidents M640 at a scope and severity Level IV. The facility's failure to provide adequate supervision to prevent the elopement of Resident #1 and Resident #2 placed these residents and other residents with diagnoses of Alzheimer's disease and	M0000		

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

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M0000	Continued from page 1 dementia at risk for elopement and the likelihood of serious injury, harm, impairment, or death. The SA notified the facility's Administrator of the Past Non-Compliance IJ and SQC on 5/26/26 at 3:15 PM. 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) and the IJ was removed as of 5/20/26, prior to the SA's entrance on 5/26/26.	M0000		
M0640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This LICENSURE REQUIREMENT is NOT MET as evidenced by: 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. 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	M0640	"Past Noncompliance - no plan of correction required"	

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M0640	Continued from page 2 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 lot, observed the residents in the parking lot, and immediately phoned the facility to report the residents outside. The investigation determined Resident #1 and Resident #2 were outside unattended for approximately 11 minutes. Resident #1 Record review of the Admission Record revealed the facility admitted Resident #1 on 2/3/24 with diagnoses including unspecified dementia, severe, with agitation and Alzheimer's disease. Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of	M0640		

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M0640	Continued from page 3 4/21/26 revealed a Brief Interview for Mental Status (BIMS) score of three (3), indicating severe cognitive impairment. Record review of the Elopement Risk Evaluation effective date, 4/22/26, the category was at risk, due to the resident having a history of elopement prior to admission while at home, she did not demonstrate exiting behavior while at the facility. Resident #2 Record review of the Admission Record revealed the facility admitted Resident #2 on 12/5/21 with diagnoses including Dementia. Record review of the Quarterly MDS with an ARD of 3/24/26 BIMS score of five (5), indicating severe cognitive impairment. Record review of the Elopement Risk Evaluation effective date, 3/24/26, category was NA (Not Applicable). On 5/26/26 at 11:45 AM, an observation was made of the route the residents were seen ambulating up the driveway. The residents ambulated approximately 90 feet from the front entrance to an open concrete driveway/entrance loop bordered by low curved concrete retaining walls with landscaped grassy areas and trees on each side. The driveway was wide, unobstructed, and led from the covered front entrance toward the outer drive/roadway area. The distance from the facility front door to the area observed was approximately 90 feet. The area was exposed to vehicle traffic; however, the residents remained within the facility parking lot. In a record review of the local weather conditions at the time of the elopement revealed on 5/18/26 at 5:30 PM, there was no rain, with the temperature approximately 80 degrees. On 5/26/26 at 12:30 PM, an interview by phone, with one of the Resident's daughters-in-law, who was driving to the facility as both Residents #1 and #2 were both outside. She confirmed that at 5:55 PM on 5/18/26, she phoned the facility to inform staff of the unattended residents outside while her husband was standing beside the residents speaking with them. She revealed staff were running outside as she was calling the facility. On 5/26/26 at 1:00 PM, during an interview with the Dietary Aide, he revealed that he was outside of the facility moving his automobile to a different location.	M0640		

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M0640	Continued from page 4 As he was driving within the facility parking lot, he observed both residents using their walkers in the facility parking lot. He attempted to speak with them, but they informed him they were allowed to be outside alone. He then immediately went into the facility and notified Registered Nurse (RN) #1. On 5/26/26 at 1:20 PM, during an interview with RN #1, she revealed that staff alerted her that both Residents #1 and #2 were outside in the facility parking lot, and staff immediately ran outside to retrieve the residents. They were both redirected and re-entered the facility. Both residents were assessed with no evidence of injuries. She notified the Director of Nursing (DON), attempted to contact both Resident Representatives, and notified the Medical Provider. She revealed both residents had not previously attempted to exit the building. On 5/26/26 at 3:00 PM, during an interview with Licensed Practical Nurse (LPN) #1, she revealed she was informed by a family member of another resident, who phoned the facility informing her that two (2) residents were outside walking in the parking lot. The family member remained with the residents until staff arrived. The residents were located on the facility driveway, not the main road. Upon locating the residents, they were redirected back into the facility. The residents ambulated back with their walkers without aggression. Staff immediately assessed both residents, notified the DON, attempted to notify the Resident Representatives, and notified the Medical Doctor (MD). Upon assessment, staff found no skin tears or injuries. The residents were then placed on one-to-one supervision until the following morning. On 5/26/26 at 3:15 PM, during an interview with the DON, he revealed the interdisciplinary team had previously assessed Resident #1 and Resident #2 and determined they were not at risk for elopement, prior to the incident. He verified both residents had diagnoses of Alzheimer's Disease and Dementia and were able to ambulate with walkers. Following the incident, both residents were reassessed for elopement risk, wander guards were applied, and additional supervision interventions were implemented. He further revealed staff were re-educated regarding monitoring residents near the facility entrance and ensuring residents did not exit the facility unsupervised. On 5/26/26 at 3:30 PM, during an interview with the Administrator, she revealed the facility investigation and video surveillance confirmed Resident #1 and Resident #2 exited the facility through the front	M0640		

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M0640	Continued from page 5 entrance behind a transportation service employee and remained outside of the facility without staff knowledge or supervision. She revealed staff were unaware the residents had exited the facility until notified by staff and a family member. The Administrator confirmed both residents were outside unattended for approximately 11 minutes on facility grounds and were not under staff supervision during that time. Following the incident, the facility reassessed both residents for elopement risk and implemented additional supervision interventions. The facility submitted the following acceptable Corrective Removal Plan on 5/27/26: This letter serves as a formal report of resident elopement that occurred on May 18, 2026, at Proper name of the facility. The facility acknowledges an Immediate Jeopardy was cited on May 26, 2026, at 3:20 PM. Resident #1 is an 89-year-old female with a diagnosis of Alzheimer's disease, unspecified dementia with agitation and a Brief Interview for Mental Status (BIMS) of 3. Resident #2 is a 79-year-old female with a diagnosis of unspecified dementia without behavioral disturbance, sequelae of cerebral infarction, and a BIMS of 5. The residents are roommates and are both ambulatory with the assistance of their walker. On 5/18/2026 at approximately 5:41 PM, a transportation service employee (Transportation Service Employee #1) exited the facility through the front door using his badge for access. At that time, Resident #1 and Resident #2 followed behind the employee. Review of security camera footage indicates that prior to the Transportation Service Employee #1's exit, Resident #1 and Resident #2 were seated in the front foyer. When Transportation Service Employee #1 opened the door to exit, Resident #1 and Resident #2 stood up and proceeded toward the exit just before the door closed. Upon exit, Resident #1 and Resident #2 sat in rocking chairs immediately to the right of the entrance until approximately 5:51 PM. At that time, Resident #1 and Resident #2 stood up and began walking toward the driveway area. A dietary employee (Dietary Employee #1), who was in his vehicle at the time, observed Resident #1 and Resident #2 in the driveway. At approximately 5:52 PM, Dietary Employee #1 approached Resident #1 and Resident #2, and asked whether they were supposed to be outside alone. Resident #1 and	M0640		

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M0640	Continued from page 6 Resident #2 both responded “yes.” Dietary Employee #1 immediately returned inside the facility and notified Registered Nurse (RN #1). At this time, the facility received an incoming call from a resident’s family member (Resident Representative #1). Resident Representative #1 stated that she and her husband were coming to the facility to visit their loved one and observed two residents standing in the driveway with their walkers. Resident Representative states they stopped to ask the residents where they were going and called in to the facility to notify staff of the residents in the driveway. At approximately 5:53 PM, RN #1 along with a Licensed Practical Nurse (LPN #1) and a Certified Nursing Assistant (CNA #1), responded promptly, located Resident #1 and Resident #2, and assisted them back into the facility. Resident #1 and Resident #2 were immediately assessed by RN #1, and LPN #1 upon re-entry into the facility and were found to be unharmed, uninjured, and free of any signs or symptoms of distress. Resident #1 and Resident #2 were placed on one-on-one monitoring until 7:00 AM on 5/19/26, at which time a Wander Guard was placed on Resident #1 and Resident #2. On 5/18/26 at 6:00 PM, RN #1 completed a head count of each resident in the facility and found all to be accounted for. On 5/18/26 at 6:45 PM, staff in-servicing began by RN #1, on elopement prevention procedures, including monitoring of exit areas, proper response to potential elopement situations, and expectations for supervision and accountability as well as staying with the resident once found. This education is intended to reinforce staff awareness and ensure consistent compliance with facility policies related to resident safety. These in-services continued on 5/19/26 by the Director of Nurses (DON) and were completed by 100% of staff on 5/19/26. No staff were allowed to work until in-serviced. On 5/19/26 at 7:00 AM, Minimum Data Set (MDS) staff completed an updated Elopement Evaluation on Resident #1 and Resident #2. Both residents were fitted with a Wander Guard device to alert staff if they are in close proximity to any exit doors. Care Plans for Resident #1 and Resident #2 was updated on 5/19/26 to reflect Wander Guard devices and increased elopement risk. The Nursing Home Administrator (NHA) notified the Mississippi State Department of Health of the incident on 5/19/26.	M0640		

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M0640	Continued from page 7 The Interdisciplinary Team (IDT) held an emergency Quality Assurance Performance Improvement (QAPI) meeting on 5/19/26. During the QAPI meeting, the facility Elopement/Missing Resident Policy was reviewed. Revisions were made to include the following: Once located, the staff member will stay with resident and notify charge nurse. Additionally, on 5/19/26, the following revisions were made to the exit and entrance procedures as a result of the QAPI meeting. The NHA contacted organizational security to remove remote entry from nurse's stations. Nursing home staff are no longer able to remotely allow visitors from the nurse station and must physically go to the door to allow entry and exit, ensuring better visibility and supervision of traffic in and out of the building. At this time, all contract employee badges were disabled. Going forward, all contract employees will be required to ring the doorbell and wait for staff assistance to allow entry and exit. Additionally, facial recognition access for family members during non-business office hours was disabled to reduce the risk of unmonitored entry and exit. A revised memorandum was posted on the inside and outside of the facility entrance to remind family members and visitors not to assist residents outside of the facility. A comprehensive facility-wide Elopement Risk Assessment was conducted and completed for all residents on 5/19/26 by the MDS team. All names and photos of residents identified as being at high risk for elopement have been updated on a designated list in the Elopement Book by the DON on 5/19/26. An Elopement Book is maintained at each Nurse Station and in the Front Office. An Elopement Drill was completed with staff by the DON on 5/19/26 at 10:45 AM. A second Elopement Drill was completed with staff by the DON on 5/19/26 at 4:00 PM. A third Elopement Drill was completed with staff by the Assistant Director of Nurses (ADON) 5/19/26 at 11:15 PM. Quality monitoring will include the DON conducting Elopement Drills weekly times four (4) weeks, then monthly times two (2) months, The IDT will have a QAPI meeting on 5/28/26 and 6/11/26 to review the monitoring process to ensure compliance is met and substantiated. The facility alleges all corrective actions were completed on 5/19/26 and the Immediate Jeopardy was removed on 5/20/2026.	M0640		

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M0640	Continued from page 8 Validation: The SA validated the removal plan through observations, interviews, and record reviews on 5/27/26 and the immediacy was removed on 5/20/26 prior to exit.	M0640		