

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255274	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/24/2024
NAME OF PROVIDER OR SUPPLIER HIGHLAND HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 638 HIGHLAND COLONY PARKWAY RIDGELAND, MS 39157		
(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 a revisit on 7/24/24 for the annual recertification survey completed on 6/20/24. During the survey, the SA determined the facility was in compliance with the compliance with Medicare and Medicaid requirements of participation licensure requirements as of 7/12/24. The facility held a license for 120 beds at the time of the survey, and the facility census was 106.	{F 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE
08/05/2024