

MSDH - Health Facilities Licensure and Certification

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                     |                                                                                                                          |                                                                    |
|----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>45HH</b>                            | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>11/05/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HIGHLAND HOME</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>638 HIGHLAND COLONY PARKWAY<br/>RIDGELAND, MS 39157</b> |                                                                                                                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                           |
| M 000                                                    | <p>Initial Comments</p> <p>On 11/05/24 the State Agency (SA) conducted three (3) onsite complaint investigations (CI) for MS #26270 for alleged sexual harrassment; CI MS #26361 for discharge and CI MS #26312 for alleged fraud. The SA determined that the facility was in compliance with the Rules and Regulations for The Aged and Infirmed and no deficiencies were cited for any of the allegations.</p> <p>The census on 11/05/24 was 117 and the facility was licensed for 120 beds.</p> | M 000                                                                                               |                                                                                                                          |                                                                    |

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

11/20/24