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 **02/26/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HOUSE NURSING CENTER	**3103 WISCONSIN AVENUE P O BOX 820485, VICKSBURG, Mississippi, 39180**

(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 an Annual Recertification Survey along with two (2) Complaint Investigations (CI MS #2740450 and CI MS #2601556), at the facility from 2/23/26 through 2/26/26. CI MS #2740450 was investigated related to call lights not answered and CI MS #2601556 was investigated related to meal menus not followed, medications not administered timely, grievance response and unaddressed nutritional concerns. There were no citations related to the Complaint Investigations. 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 requirement and cited M500, M815, and M1570.	M0000		
M0500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as	M0500		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **02/26/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HOUSE NURSING CENTER	**3103 WISCONSIN AVENUE P O BOX 820485, VICKSBURG, Mississippi, 39180**

(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
M0500	Continued from page 1 documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be	M0500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **02/26/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HOUSE NURSING CENTER	**3103 WISCONSIN AVENUE P O BOX 820485, VICKSBURG, Mississippi, 39180**

(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
M0500	Continued from page 2 used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically	M0500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **02/26/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HOUSE NURSING CENTER	**3103 WISCONSIN AVENUE P O BOX 820485, VICKSBURG, Mississippi, 39180**

(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
M0500	Continued from page 3 contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on observation, interview, record review, and facility policy review, the facility failed to ensure Resident #5's right to reasonable accommodation of her physical limitations by not maintaining a call light within reach and not providing a call light she could independently activate to request assistance, for one (1) of nineteen (19) residents sampled. Findings include: A review of the facility's policy, "Call Light/Bell" revealed, "Purpose…provide the resident a means of communication with staff members…Procedure 1. Ensure resident has call light in reach when in resident room…7. Place the call light within the resident's reach before leaving the room…" A record review of the "Face Sheet" revealed the facility admitted Resident #5 on 10/25/24 with diagnoses including Hemiplegia and Hemiparesis following Cerebral Infarction affecting the left non-dominant side. A record review of the "Functional Assessment" dated 2/18/26 revealed Resident #5 had upper one-sided limitations, was dependent, and required maximal assistance with all activities of daily living (ADLs). A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/18/26 revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of three (3), which indicated the resident's cognition was severely impaired. On 02/23/2026 at 1:45 PM, during an observation, Resident #5 was in bed and stated she wanted water. The call light was positioned between the bed rail and mattress, hanging near the floor and out of reach. A water pitcher was observed on the bedside stand. The	M0500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **02/26/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HOUSE NURSING CENTER	**3103 WISCONSIN AVENUE P O BOX 820485, VICKSBURG, Mississippi, 39180**

(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
M0500	Continued from page 4 resident was unable to access the call light. The Physical Therapist Assistant (PTA) retrieved the call light from between the bed rail and mattress and confirmed it had been out of the resident's reach. The resident had a dome-shaped "soft" call light and was unable to independently press the button to request assistance. On 02/25/2026 at 12:06 PM, during an observation, Resident #5 was seated upright in a chair with a splint in place on the left arm. The call light was observed on the bed and was again out of the resident's reach. On 02/25/2026 at 9:02 AM, during an interview, the Consultant and Administrator reported that after meeting with therapy staff, the facility decided to order a different type of call light to allow Resident #5 to activate a "bump" style device and added an intervention to increase rounding to every hour. On 02/25/2026 at 2:56 PM, during an interview, the Director of Nursing (DON) stated Resident #5 had a splint related to a prior stroke and confirmed a tent-style call light had been ordered because the resident was unable to activate the current device independently. On 02/26/2026 at 3:12 PM, during an interview, the Administrator stated staff were expected to follow established guidelines and ensure resident needs were met.	M0500		
M0815	45.29.1 Safe Food Handling Procedures Safe Food Handling Procedures. Food shall be prepared, held, and served according to current Mississippi State Department of Health Food Code Regulations. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on observation and staff interview the facility failed to ensure sanitary food handling practices were maintained by failing to sanitize a food thermometer between checking temperatures of multiple food items on the steam table for one (1) of three (3) kitchen observations. Findings include: On 02/24/2026 at 3:37 PM, during an observation and interview, the Cook was observed standing at a two-tiered table with individual packs of cleaning	M0815		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **02/26/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HOUSE NURSING CENTER	**3103 WISCONSIN AVENUE P O BOX 820485, VICKSBURG, Mississippi, 39180**

(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
M0815	Continued from page 5 wipes on the bottom shelf. The Cook retrieved a cleaning wipe and performed an initial cleaning of the thermometer. She then checked the temperature of each food item on the steam table using the same thermometer without sanitizing the thermometer wand between food items. The Cook confirmed she checked the temperature of all foods without sanitizing between items and stated it was important to keep the thermometer clean to prevent cross-contamination. During the same interview, the Dietary Manager (DM) confirmed it was the Cook's responsibility to maintain sanitary conditions on the food line. The DM stated staff received monthly in-service training, she expected proper food handling practices, and she would increase monitoring and provide reminders to staff. On 02/25/2026 at 9:46 AM, during an interview, the Administrator stated she had been informed of the kitchen practices. The Administrator stated kitchen staff and management were responsible for maintaining sanitary food handling practices. She stated she would increase monitoring in the kitchen and expected staff to consistently maintain sanitary conditions.	M0815		
M1570	48.58.1 Infection Control The following infection control standards shall be met: 1. The facility must maintain and document an effective infection control program that protects patients, families, visitors, and facility personnel by preventing and controlling infections and communicable diseases. 2. The facility must have an active surveillance program that includes specific measures for prevention, early detection, control, education, and investigation of infections and communicable diseases in the facility. There must be a mechanism to evaluate the effectiveness of the program(s) and take corrective action when necessary. The program must include implementation of nationally recognized systems of infection control guidelines to avoid sources and transmission of infections and communicable diseases. 3. The facility must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions. This LICENSURE REQUIREMENT is NOT MET as evidenced by:	M1570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **02/26/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HOUSE NURSING CENTER	**3103 WISCONSIN AVENUE P O BOX 820485, VICKSBURG, Mississippi, 39180**

(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
M1570	Continued from page 6 Level II Based on observation, interview, record review, and facility policy review, the facility failed to implement Enhanced Barrier Precautions (EBP) as required during wound care for one (1) of two (2) wound care observations, Resident #18. Findings include: A review of the facility's policy, "Enhanced Barrier Precautions," with the latest review date of 03/24, revealed, "Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., … residents with wounds or indwelling medical devices) … Wounds generally include chronic wounds, not shorter-lasting wounds, such as skin breaks or skin tears covered with an adhesive bandage (e.g. Band-Aid) or similar dressing. Examples of chronic wounds include, but are not limited to, pressure ulcers…" A record review of the "Face Sheet" revealed the facility admitted Resident #18 on 12/26/2025 with diagnoses including Hemiplegia and Hemiparesis. A record review of Resident #18's "Order Summary Report" with active orders as of 02/26/2026 revealed, "… Clean Stage 2 pressure ulcer to left hip with normal saline. Apply collagen to wound and cover with dry dressing, daily until healed. One time a day for Stage 2 pressure wound … order date 02/09/2026 … start date 02/10/2026 …" A record review of the Part A PPS Discharge Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/08/2026 revealed Section C indicated Resident #18 was rarely/never understood. Section M0210 revealed the resident had one (1) or more unhealed pressure ulcers/injuries. On 02/25/2026 at 9:40 AM, during an observation and interview, wound care was performed by Registered Nurse (RN) #3 and assisted by the Director of Nursing (DON). Enhanced Barrier Precautions signage was observed above the resident's headboard and personal protective equipment (PPE) was hanging on the back of the door. During the wound care, neither RN #3 nor the DON wore a	M1570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **02/26/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HOUSE NURSING CENTER	**3103 WISCONSIN AVENUE P O BOX 820485, VICKSBURG, Mississippi, 39180**

(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
M1570	Continued from page 7 gown while providing and assisting with wound care. During the same interview following the procedure, both staff confirmed they did not wear gowns and stated they forgot to don the required PPE. On 02/25/2026 at 3:00 PM, during an interview, Licensed Practical Nurse (LPN) #1 reported that residents with pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, venous stasis ulcers, or indwelling catheters were placed on Enhanced Barrier Precautions with signage above the headboard and PPE stored in the room. She confirmed Resident #18 had been on Enhanced Barrier Precautions since acquiring the pressure wound and stated staff were educated on EBP and were expected to wear PPE when providing care. On 02/26/2026 at 3:23 PM, during an interview, the Administrator stated she expected all staff to follow Enhanced Barrier Precautions when providing care to residents with wounds or other conditions requiring PPE.	M1570		