

Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 934		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/30/2026	
NAME OF PROVIDER OR SUPPLIER HIGHLAND HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 638 HIGHLAND COLONY PARKWAY , RIDGELAND, Mississippi, 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
M0000	Initial Comments The State Agency (SA) conducted an onsite Complaint Investigations (CI MS# 2963762) at the facility on 3/30/26. During the survey, the SA determined the facility was not in compliance with the Minimum Standards of Operation for Institutions of Aged or Infirm, state licensure requirements, which was investigated for Accident Hazards, and M640 was cited at an Immediate Jeopardy (IJ). The facility failed to provide adequate supervision to prevent the elopement of Residents #1 and Resident #2, who had exhibited exit-seeking behaviors. This failure allowed Residents #1 and Resident #2 to exit the facility unnoticed and unsupervised when a visitor was observed on video on 3/24/2026 at 6:20 PM holding the door open for the residents to exit. A nurse immediately responded to the door alarm sounding and went outside down the walkway but did not see the residents. Staff then searched for the residents and found both residents across a four-lane high-capacity road in front of the facility at 6:33 PM. The weather at the time was cloudy and the temperature was 71 degrees Fahrenheit; both residents were dressed in closed-toe shoes, pants, and long-sleeve shirts. The facility's failure to provide adequate supervision to prevent the elopement of Residents #1 and Resident #2 placed these residents, and other residents at risk for wandering and elopement, in a situation that was likely to cause serious injury, harm, impairment, or death. The SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC), which began on 3/24/26 and existed at Rule 45.21.8 Accidents - M640 Level IV The SA notified the facility's Administrator of the IJ and SQC on 3/30/26 at 3:00 PM. Based on the facility's implementation of corrective actions on 3/25/26, the SA determined the IJ and SQC to be Past Non-Compliance (PNC), and the IJ was removed as			M0000			

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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M0000	Continued from page 1 of 03/26/26, prior to the SA's entrance on 3/30/26. The facility held a license for 120 beds, with a census of 107.		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 observation, interview, record reviews, and facility policy review, the facility failed to provide adequate supervision to prevent vulnerable residents from leaving the facility unnoticed and unsupervised for 2 (two) of 7 (seven) residents who were at risk for elopement and wandering. Resident #1 and Resident #2. The facility failed to provide adequate supervision to prevent the elopement of Residents #1 and Resident #2, who had exhibited exit-seeking behaviors. This failure allowed Residents #1 and Resident #2 to exit the facility unnoticed and unsupervised when a visitor was observed on video on 3/24/2026 at 6:20 PM holding the door open for the residents to exit. A nurse immediately responded to the door alarm sounding and went outside down the walkway but did not see the residents. Staff then searched for the residents and found both residents across a four-lane high-capacity road in front of the facility at 6:33 PM. The weather at the time was cloudy and the temperature was 71 degrees Fahrenheit; both residents were dressed in closed-toe shoes, pants, and long-sleeve shirts. The facility's failure to provide adequate supervision to prevent the elopement of Residents #1 and #2 placed these residents, and other residents at risk for wandering and elopement, in a situation that was likely to cause serious injury, harm, impairment, or death. The State Agency (SA) identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 3/24/26 and existed at Rule 45.21.8 Accidents - M640 Level IV The SA notified the facility's Administrator of the IJ and SQC on 3/30/26 at 3:00 PM. Based on the facility's implementation of corrective		M0640	"Past Noncompliance - no plan of correction required"			

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M0640	Continued from page 2 actions on 3/25/26, the SA determined the IJ and SQC to be Past Non-Compliance (PNC), and the IJ was removed as of 03/26/26, prior to the SA's entrance on 3/30/26. Findings Included: Review of the facility policy "Elopement/Wandering - Security System" with revision date of 03/25 revealed, "Policy: To provide a safety system... to implement protective measures to help guard against a resident wandering /eloping from the facility. Residents who are incapable of adequately protecting themselves which are unable to determine when they are at risk for harm by wandering out of the facility, should be placed on the Resident Security System to ensure safety..." An interview on 03/30/26 at 9:45 AM with the Administrator (ADM), revealed that on 03/24/26 at approximately 6:10 PM, Resident #1 and Resident #2 exited the facility door on foot. She revealed these two residents were ambulatory, they wandered throughout the facility, often together, and were at risk of elopement. She revealed that they had wander guard bracelets on and when they exited the door to the outside, the alarm sounded and this alerted staff. ADM revealed that Licensed Practical Nurse (LPN) #2, heard the door alarm going off, she alerted other staff and they searched until they found them across the street from the facility. Administrator revealed that a staff member drove across the street in her car and brought the residents back to the facility safely. Administrator revealed that she viewed the video camera coverage and discovered that a visitor entered the facility at 6:20 PM, Resident #1 and Resident #2 walked up to the door and this visitor held the door open for the two ladies, and they walked outside. ADM also revealed that she observed during review of the video that Resident #1 and Resident #2 had approached the door together two or three times prior to this occurrence. An observation on 03/30/26 at 10:05 AM revealed Resident #1 lying in bed awake and she had a wander guard bracelet above her right ankle. Resident could answer simple questions and could not recall that she had been outside the facility on the day of the elopement. On 03/30/26 at 10:20 AM, the State Agency (SA) reviewed video surveillance coverage for the date of 03/24/26 and confirmed that a visitor entered the facility at approximately 6:20 PM, the two residents (Resident #1 and #2) approached the door, and the visitor held the door open for the two ladies, and they walked out of			M0640			

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M0640	Continued from page 3 the building. The video camera footage viewed also confirmed that Residents #1 and #2 were brought back into the facility at 6:33 PM accompanied by staff. Resident #1 and Resident #2 were observed to have on long sleeve shirts, pants and closed toe shoes at the time of the elopement. An interview on 03/30/26 at 10:30 AM with the Assistant Administrator, revealed that Resident #1 walked a lot in the facility and most of the time had her purse over her shoulders and stated, "Unless you worked there, you would think she was a visitor." He revealed that Resident #2 was more of a follower, a "tag along." He revealed that the two mentioned residents were roommates and good friends, and they saw them often walking together throughout the facility. He revealed that they had other residents with wander guard bracelets who they monitored but were wheelchair bound and non-ambulatory. An observation on 03/30/26 at 10:33 AM revealed Resident #2 participating in an activity. She mumbled and could not carry on a normal conversation due to mental status. There was a wander guard bracelet on her right ankle. An interview on 03/30/26 at 10:47 AM with Certified Nursing Assistant (CNA) #1, revealed that she was working on 03/24/26 on a different hall from Resident #1 and Resident #2. She revealed that she was doing trays when she heard a "Code W" called over the intercom. She revealed that she was panicky and checked all halls and rooms and found out that Residents #1 and #2 had gotten out. She revealed that she ran outside along with two other staff, ran to the end of the walkway and around the corner of the facility and spotted them (Residents #1 and #2) across the street. CNA #1 revealed that the residents had walked outside to the end of the walkway, walked around the right side of the building and crossed the four- lane highway. She revealed that she (CNA #1) ran across the street to where the two residents were and stated, "I thanked God nothing happened." She revealed that this was very scary, that people "fly up and down that road" in their vehicles and she was thankful that Resident #1 and Resident #2 were not hit by a car or worse and stated, "I'm so glad we got them back." She revealed that this place is now locked up tight and now if residents get out, it will be because of a staff member who opens the door. CNA #1 revealed that now they change the codes frequently and only staff were allowed to have the codes. An interview on 03/30/26 at 2:15 PM with the Director			M0640			

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M0640	Continued from page 4 of Nursing (DON), revealed that on 03/24/26 at 6:45 PM, she received a call from Registered Nurse (RN) Supervisor reporting that Resident #1 and Resident #2 had gotten out of the facility after a visitor held the door open for them. She revealed that when she arrived at the facility, body audits were completed and there were no injuries identified and neither resident could recall what happened. She revealed that they were placed on 1:1 supervision for the rest of the shift. DON revealed that they "swept" the building to make sure everyone was accounted for, they used the transmitter from the medication cart and checked all wander guard bracelets to ensure proper functioning. She revealed that they also checked all doors in the facility and codes were changed. She revealed that they initiated in-services. DON revealed that they had signage on the door about not allowing residents to exit with visitor and they took an extra step and updated the Kiosk. She revealed that they now made sure everyone who entered the facility checked in on the Kiosk and they added an extra step they had to agree that no resident comes in or out of the facility with them and if they did not choose to accept on the kiosk, it alerted staff to check it out. DON revealed that there were endless risks with the elopement including the timing, the highway was busier during certain times of the day than others and she agreed that Resident #1 and Resident #2 could have been hit by a car, injured or worse. She revealed that she was thankful for staff who acted promptly and had Resident #1 and Resident #2 back safely inside the building in about thirteen minutes. DON revealed that Resident #1 and Resident #2 were always walking in the facility and most of the time together and confirmed that this was the first time they had ever gotten outside. She also revealed that Resident #1 and Resident #2 had wandered to the doors and looked out but they had not noticed them trying to get out. DON revealed that this was terrifying and gave them an unrealistic fear and stated, "Our primary goal here is for them to be safe." She revealed that they investigated the incident, they held an Emergency Quality Assurance (QA) Meeting and found the root of the problem. She agreed that if they had increased monitoring in place, it could have prevented Resident #1 and Resident #2 from leaving the building and had they not been allowing visitors to have the door codes, this would not have happened. She revealed that if the staff were the ones with the door codes, they could better monitor who goes in and out of the facility. She stated, "We have so many things to be thankful for in this situation." An interview on 03/30/26 at 2:40 PM with the Maintenance Director, revealed that he measured the distance from the exit door that Resident #1 and Resident #2 exited from to			M0640			

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M0640	Continued from page 5 the place across the street where they were located and the distance was approximately 528 feet. An interview on 03/30/26 at 2:45 PM with LPN #1, revealed that Resident #1 and Resident #2 were pleasantly confused and they walked around in the facility together a lot. She revealed that on 03/24/26, she was working on the medication cart and heard that Resident #1 and Resident #2 had left the building. She revealed that she immediately went outside, walked to the end of the walkway and saw them across the street and confirmed that they had crossed a four-lane highway. She revealed that things could have been worse, the residents could have fallen, they could have wandered around for hours without being found, or they could have been hit by a car, causing injury or worse. She stated, "I'm thankful they didn't get far or get hurt." LPN #1 revealed that she got into the car and drove across the street to get them and returned Resident #1 and Resident #2 back to the facility. She revealed that they checked them out good and they had no injuries. Record review of the facility's final "Investigation Report" revealed that on Tuesday, March 24, 2026, at approximately 6:20 PM, an incident occurred involving Resident #1 and Resident #2. These two residents were ambulatory and were walking toward the exit door when a visitor entered and held the door open, allowing Resident #1 and #2 to exit the facility door. The residents had Wanderguard bracelets on and immediately the door alarm sounded. In review of the video surveillance, a nurse responded and exited the facility. Additional staff were notified and exited the facility to locate the residents. Resident #1 and Resident #2 were returned back to the facility and assessed for injury or harm with none noted. Record review of Resident #1's "Elopement" report revealed, "Notified per nursing staff that resident not on the B unit and unable to locate resident. All staff notified and searching for resident. RN supervisor went outside B Unit searching for resident. Writer noted car with x (times) 3 (three) staff members and x2 (two) residents getting out of the car. Informed that resident found across the street by (proper name) Nursing Home. Resident assisted back into the building. When asked resident where she was going, resident confused and did not realize she had left out of the building. Resident assisted to room. Body audit conducted. No skin impairment or physical injuries noted at present.Resident placed on 1:1 observation due to elopement risk." Under "Predisposing Physiological Factors" was documented that she was			M0640			

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M0640	Continued from page 6 confused with impaired memory and that she was a wanderer. Record review of Resident #1's "Progress Notes" dated 03/25/26 at 18:20 (6:20 PM) documented "Notified resident not on unit. Unable to locate resident. All staff notified. Resident located outside per staff and assisted back into facility. Resident alert and responsive. Oriented with intermittent confusion noted.....Body audit conducted. No skin impairment noted. No injuries noted at present.....Resident placed on 1:1 observation. On call provider notified. RP (Responsible Party) notified. Leadership notified." Record review of Resident #1's "Face Sheet" revealed an admission date of 04/26/24 with diagnoses that included Unspecified Dementia and Wandering. Record review of Resident #1's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 01/21/26 under Section C revealed a Brief Interview for Mental Status (BIMS) Score of 03 which indicated that she had severe cognitive deficits. Section P of MDS Assessment revealed that Resident #1 had a Wander/elopement alarm in place and it was used daily. Record review of Resident #2's "Face Sheet" revealed an admission date of 01/14/25 with diagnoses that included Unspecified Dementia and Cognitive Communication Deficit. Record review of Resident #2's MDS with ARD of 01/16/26 under Section C revealed a BIMS Score of 00 which indicated that she had severe cognitive deficits. Under Section P of the MDS Assessment, documentation revealed that Resident #2 had a Wander/elopement alarm in place and it was used daily. Record review of Resident #2's "Elopement" report dated 03/24/26 at 18:20 (6:20 PM) revealed, "Notified per nursing staff that resident not on the B unit and unable to locate resident. All staff notified and searching for resident. RN supervisor went outside B Unit searching for resident. Writer noted car with x3 (three) members and x2 residents getting out of the car. Informed that resident was found across the street by (proper name) Nursing Home. Resident assisted back into the building. When asked resident where she was going, resident did not respond to question. Resident alert and oriented with intermitted confusion. Resident assisted to room. Body audit conducted. No skin impairment or physical injuries noted at present.....Resident placed on 1:1 observation due to elopement risk." Under "Predisposing Physiological			M0640			

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M0640	Continued from page 7 Factors" was documented that Resident #2 was confused and had impaired memory. It was also documented that she was a wanderer. Record review of Resident #2's "Progress Note" dated 03/24/26 at 18:20 revealed, "Notified resident not on unit. Unable to locate resident. All staff notified. Resident located outside per staff and assisted back into facility. Resident is alert and responsive. Oriented with intermittent confusion noted..... On call provider notified, RP notified. Leadership notified." Immediate Actions: 1. Facility search was conducted on 03/24/26. 2. Police notified of missing resident. 3. Interviewed staff and residents conducted by Director of Nursing on 03/24/26. 4. Medical Director and Residents' Family notified on 03/24/26. 5. Wander guard system and facility doors checked by Administrator and Director of Nursing to ensure proper functioning. 6. Resident returned to facility on 03/24/26 at 6:33 PM 7. Incident Report completed on 03/24/26. 8. Emergency Quality Assurance (QA) Meeting completed on 03/24/26. 9. In-service training initiated on 03/24/26 by Director of Nursing with all staff to include elopement policy. Comprehension of training validated by successful response to the quiz presented to each employee. Staff, including contract staff were not allowed to work their next scheduled shift until in-servicing had been completed. The compliance was monitored by Administrator. Corrective Actions Timeline: Review of Monitoring Actions: 1. Wanderguard system checks were monitored by Director of Nursing on 03/24/26 and then planned to continue three times weekly for four weeks or until substantial			M0640			

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M0640	Continued from page 8 compliance has been attained. 2. Resident behavior for elopement attempts will be monitored via incident reports, observations and communications by Director of Nursing beginning 03/24/26 and to continue weekly for four weeks or until substantial compliance has been attained. 3. The facility QA Committee will meet for the next 4 weeks to review compliance with the plan of action. If no further concerns are noted, will continue to monitor as per routine facility QA Committee. Corrective Actions Timeline: 1. On March 24, 2026, at approximately 6:20PM., Visitor #1 opened the door on Unit B and allowed Resident #1 and Resident #2 to exit the facility. Resident #1 and Resident #2 were wearing Secure Care wander guard bracelets which initiated the door alarm to sound. Staff Licensed Practical Nurse #1 responded to the door alarm at approximately 6:20 PM and went outside the door immediately to locate Resident #1 and Resident #2. Staff Licensed Practical Nurse #1 returned inside and notified additional staff which consisted of certified nurse aides, and licensed nurses of the absence of Resident #1 and Resident #2. The additional staff responded and exited the facility to locate Resident #1 and Resident #2. Resident #1 and Resident #2 were located across the street approximately 528 feet from the exit door. At approximately 6:33 p.m., Resident #1 and Resident #2 were escorted back into the facility by the RN Supervisor, Staff Nurse #1 and Certified Nursing Assistant #1 with no harm or injury. Approximately 6:45 p.m., the Director of Nurses and Administrator were notified and enroute to the facility. 2. On March 24, 2026, at approximately 7:00 PM, the Administrator reviewed video surveillance and confirmed that a Visitor #1 held the door open on Unit B and allowed Resident #1 and Resident #2 to exit the facility at approximately 6:20 PM. The Director of Nurses contacted the Medical Director on March 24, 2026, at approximately 7:30 PM, and an emergency Quality Assurance meeting was held at that time involving the Medical Director, Director of Nursing, the Administrator, Regional Director, Licensed Practical Nurse #1, Certified Nursing Assistant #2, Certified Nursing Assistant #3, and the Infection Preventionist. 3. On March 24, 2026, at approximately 8:00 PM, the			M0640			

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M0640	Continued from page 9 Administrator changed the door code on main entry door. On March 24, 2026, at approximately 8:00 PM the Administrator checked all entry doors to ensure signage remained in place to not allow residents to exit facility unaccompanied. All entrance door signage was confirmed to be in place. The Director of Nursing identified 7 (seven) residents at risk and ensured elopement bracelets and transmitters were functional and the doors were locking appropriately. No areas of concern were noted during bracelet, transmitter and doors checks. All were functioning appropriately. The Director of Nursing reviewed care plans of 7 of 101 residents at risk. No areas of concern were noted with the care plan audit. Body audits were performed on Resident #1 and Resident #2 by the Registered Nurse Supervisor and Licensed Practical Nurse #2. On March 24, 2026, audits were conducted including not limited to resident location, risk for elopement, Secure Care wander guard bracelet and function all verified by the Director of Nursing. Additionally, Medical Records conducted an audit on 3/25/2026 updating all care profiles of residents at risk for wandering. On 3/25/2026, the Assistant Administrator began audits of all doors for function and security. On March 24, 2026, In- services were initiated by the Director of Nurses and Staff Development Coordinator with all staff. Inservice topics included the Elopement policy and procedure, Resident Rights, and Incident / Accident Reporting. On March 25, 2026, Elopement Drills (Code W) were conducted on each shift by the Administrator, Director of Nursing and the Staff Development Coordinator. On March 25, 2026, monitoring systems were put in place to sustain compliance. The facility Administrator will have a follow-up QA meeting monthly for two months then quarterly afterwards to ensure sustained compliance. On March 25, 2026, the facility entry screening was updated to include an additional reminder to ensure resident safety. Administration spoke directly with Visitor #1 to confirm visitor policies and procedures. The facility alleges all corrective actions were completed on 3/25/2026 and the Immediate Jeopardy was removed on 3/26/2026. On 03/30/26, the SA validated during the onsite complaint investigation through interviews, observations and record reviews that all corrective actions had been taken by the facility to remove the Immediate Jeopardy and the Immediate Jeopardy was removed on 03/26/26 prior to the SA entrance on			M0640			

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(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
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