

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/01/2021
FORM APPROVED
OMB NO. 0938-0391

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 C 06/15/2021
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 CI MS #17792 & CI MS #17821 The State Agency (SA) conducted a complaint survey from 6/14/21 through 6/15/21. During the survey, the SA determined the facility was in compliance with the requirements of the participation of Medicare and Medicaid. The SA did not substantiate CI MS #17821 for Quality of Care for facility staffing, concerns for Infection Control related to Covid, Pharmaceutical Services related to expired and discontinued narcotics needing to be removed from the medication carts, and lack of a DON and RN supervisor. The SA did not substantiate CI MS #17792 for Quality of Care for resident left soiled and wet for extended periods, Quality of care related to call bells not answered in a timely manner, resident not receiving some medications, and staff being rude and mean. No deficiencies were cited. The census at the time of the survey was 85 and held a license for 120 beds.	F 000			

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.