STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255274	A. BUILDING _____ B. WING _____	10/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND HOME	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 #16230, CI MS #16306 & CI MS #16351 The State Agency (SA) conducted an annual recertification along with complaints, MS #16230, MS #16306 and MS #16351 from October 28, 2019 to October 31, 2019. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid. The SA did not substantiate MS #16230 or MS #16306 related to staffing or quality of care with no citations related to the complaints. The SA did not substantiate MS #16351 related to quality of care, with no citations related to the complaint. The SA cited F641 and F880 during the survey. The census was 111, and the facility was licensed for 120 beds.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to accurately code the Minimum Data Set (MDS) for Hospice, for two (2) of 21 residents reviewed, Resident #30 and Resident #44. Findings include: Record review of the facility's "Resident MDS Assessment" policy, dated 9/19, revealed The Registered Nurse is responsible for verifying the	F 641	By submitting the enclosed materials we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceeding and submit these responses pursuant to our regulatory obligations. F 641 * On 10/31/2019, Resident #30 s Quarterly Minimum Data Set (MDS) was	11/14/19

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

Electronically Signed | 11/13/2019

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F 641	Continued From page 1 completion of the assessment. The completed assessment guide the staff in identifying key information about the resident and serves as a a basis for identifying resident specific issues and objectives in order to develop a care plan. The assessment will describe the resident's physical and mental deficits, strengths and the requirements of assistance to meet their needs. The assessment will also identify risk factors associated with possible functional decline and describe the resident's objectives for maintaining or improving their functional abilities. Resident #44 Review of Resident #44's Significant Change MDS, with an Assessment Reference Date (ARD) of 6/11/19, revealed Hospice was not marked. Record review of the Quarterly MDS with an ARD of 9/6/19, revealed Dialysis was not marked. On 10/29/19 at 4:10 PM, during an interview, Licensed Practical Nurse (LPN) #1/MDS Nurse confirmed Resident # 44 had an order to be admitted to Hospice on 6/5/19. The MDS Nurse stated the significant change MDS on 6/11/19, and the quarterly MDS on 9/6/19, did not have Hospice coded. LPN #1 stated Hospice should have been coded and they will have to do a modification. On 10/29/19 at 4:20 PM an interview with LPN #2 confirmed she completed the MDS with an Assessment Reference Date (ARD) of 6/11/19 and 9/6/19. LPN # 2 confirmed that she did not code Resident #44 was receiving treatment by Hospice. LPN #2 revealed she did the significant change MDS on 6/11/19, because Resident #44 was admitted to Hospice, but did not mark Hospice in section "O". LPN #2 revealed she	F 641	modified to correct Section O related to Hospice Services by the Assessment Nurse. Resident #44 s Quarterly and Significant Change MDS assessments were modified and corrected by the Assessment Nurse on 11/1/2019 to reflect resident s hospice status. * On 11/13/2019, the Administrator reviewed the current MDS assessments of residents receiving hospice care to ensure accuracy of MDS, with no other issues identified. * On 10/30/2019, the Quality Improvement Nurse in-serviced the facility s MDS nurses related to accuracy of resident Minimum Data Sets according to the facility s policy and the Resident Assessment Instrument (RAI) Manual. On 11/14/2019, the Quality Assurance Committee reviewed the policy, Resident MDS Assessment with no recommended changes to the facility. * The Director of Nurses (DON) will assess three (3) residents most current MDS assessment for accuracy weekly for five (5) weeks through the facility s Utilization review meeting. The Quality Assurance (QA) Committee will evaluate the DON assessments two (2) times a month for 2 months and make recommendations and/or changes needed to ensure ongoing compliance with F tag 641.	

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F 641	Continued From page 2 gets her information for the MDS from the resident's chart and reviewing the orders, and must have just missed that section. Review of the current physician's orders, for Resident #44, revealed an order noted on 6/5/19, to admit to Hospice with a diagnosis of Heart Disease. Resident #30 Review of Resident #30's Quarterly MDS, with an ARD of 9/5/19, revealed Hospice was not marked. On 10/30/19 at 1:05 PM, during an interview, Licensed Practical Nurse (LPN) #3/Minimum Data Set (MDS) Nurse confirmed she completed the MDS, with an ARD of 9/5/2019. LPN #3 confirmed she did not code the MDS to reflect Resident #30 was receiving treatment by Hospice. LPN #3 stated " I just missed it". She stated Hospice should have been marked. Review of the current physician's orders revealed an order noted on 6/5/19, to admit Resident #30 to Hospice with a diagnosis of Hypertensive Heart Disease with Heart Failure.	F 641		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		11/14/19

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F 880	Continued From page 3 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct	F 880		

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F 880	Continued From page 4 contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review, the facility failed to properly store the oxygen (O2) tubing for one (1) of 34 residents utilizing oxygen, Resident #186. Findings include: Review of the facility's "Infection Control Oxygen Equipment Cleaning", policy, latest revision 03/18, revealed, "...10. When not in use, store the mask/cannula in a plastic bag clearly labeled with the resident's name and date". Review of the facility's "General Infection Prevention and Control Nursing Policies", dated 06/14, revealed, "It is the policy of this facility that all nursing activities will be performed in a manner to minimize the potential for infection in residents, staff, and visitors".	F 880	F 880 " On 10/29/2019, Registered Nurse (RN) #1 replaced the oxygen tubing for Resident #186. Resident #186 was assessed on 11/4/2019 by the Director of Nurses (DON), with no adverse findings noted. " On 11/4/2019, the DON Nurses and Assistant Director of Nurses (ADON) audited the tubing of all residents requiring Oxygen therapy, with no new issues identified. " On 11/14/2019, the DON and Staff Development Coordinator in-serviced nursing staff related to Oxygen therapy and Infection Control. All other direct care staff will be in-serviced prior to patient care assignment. On 11/14/19, the Quality Assurance (QA) Committee	

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F 880	Continued From page 5 On 10/29/19 at 2:30 PM, observation of Resident #186, revealed the O2 tubing was hanging across the top of the concentrator and onto the floor behind the concentrator. 10/29/19 at 2:35 PM, during an interview and observation, Registered Nurse (RN) #1 confirmed the O2 tubing for Resident #186 was on the floor. RN #1 disconnected the tubing from the concentrator and stated she was going to get a new tubing, because it was on the floor and was an infection control issue. On 10/30/19, at 2:42 PM, during an interview, the Director of Nursing (DON) stated with the oxygen tubing being found on the floor, anything could have gone up the tubing and gotten into the resident's airway. She stated the facility policy for Oxygen Therapy and infection control was not followed.	F 880	reviewed the policies, Infection Control Oxygen Equipment Cleaning and General Infection Prevention and Control nursing policies, with no recommended changes to the policy. " The DON will audit three (3) residents receiving oxygen per day 3 days a week for five (5) weeks to ensure proper Infection Control related to Oxygen therapy. The Quality Assurance (QA) Committee will evaluate the DON assessments two (2) times a month for 2 months and make recommendations and/or changes as needed to ensure ongoing compliance with F tag 880.	

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	255274	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/31/2019**

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000		

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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.

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E 000	Initial Comments ********** Survey conducted on 10/31/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were cited.	E 000		

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