

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 09/03/2026	
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 Annual Recertification survey along with three (3) Complaint Investigations (CI MS #3015432, CI MS #3066914, and CI MS #2984747) at the facility from 08/31/26 through 09/03/26. The SA investigated FRI MS #2984747 and cited M640. Based on the facility's implementation of corrective actions prior to survey entrance, the SA determined M640 was past noncompliance. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm and cited, M500, M610, M625, M640, M715, M780, and M1570. The SA investigated CI MS #3015432 and CI MS #3066914 with no deficiencies cited. The census at the time of the survey was 110 and the facility held a license for 120 beds.			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 documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in			M0500			

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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M0500	Continued from page 1 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 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;			M0500			

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M0500	Continued from page 2 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 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			M0500			

Mississippi State Department of Health

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M0500	Continued from page 3 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, staff interviews, record review, and facility policy review, the facility failed to ensure residents rights were honored as evidenced by failing to conceal a urinary catheter drainage bag from public view for two (2) of eight (8) residents reviewed for dignity with urinary catheter drainage bags. Resident #20 and Resident #92 Findings Include: Review of facility policy titled "Dignity and Respect" with a revision date of 07/22 revealed, "A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility shall protect and promote the rights of the residents..." Resident #20 During an observation on 8/31/26 at 4:02 PM, Resident #20, who was nonverbal, was seated in a recliner in his room with the door open. The resident's urinary catheter drainage bag was attached to the lower edge of the recliner and was not covered by a privacy bag. Less than 200 mL (milliliters) of yellow, cloudy urine was visible in the drainage bag. An interview with Licensed Practical Nurse (LPN) #6 on 9/01/26 at 11:21 AM revealed privacy covers were not placed over urinary catheter drainage bags while residents were in their rooms. LPN #6 confirmed the privacy covers were used only when residents left their rooms. An interview with the Director of Nursing (DON) on 9/1/26 at 11:48 AM revealed urinary catheter drainage bags should always be covered. The DON confirmed that leaving the drainage bags uncovered created a dignity concern for residents. Record review of the "Face Sheet" revealed the facility admitted Resident #20 on 7/30/26 with medical diagnoses that included obstructive and			M0500			

Mississippi State Department of Health

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M0500	Continued from page 4 reflux uropathy and retention of urine. Record review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 8/5/26, revealed under Section C a Brief Interview for Mental Status (BIMS) summary score of 99, which indicated Resident #20 was unable to complete the interview. Resident #92 An observation on 8/31/2026 at 11:35 AM revealed Resident #92's room door was open, and her urinary catheter drainage bag containing yellow urine was hanging on the side of the resident's bed and visible from the hallway. The catheter drainage bag was not covered by a privacy bag. An observation on 8/31/2026 at 3:30 PM revealed Resident #92's urinary catheter drainage bag was uncovered and visible from the hallway. The drainage bag contained approximately 1,000 milliliters (mL) of yellow urine. An observation from the hallway on 9/1/2026 at 8:40 AM revealed Resident #92's urinary catheter drainage bag was uncovered, contained urine, and was visible from the hallway. During an interview on 9/1/2026 at 11:15 AM, Certified Nursing Assistant (CNA) #1 revealed that when he began to give Resident #92 a bed bath, he noticed the resident's urinary catheter drainage bag was visible from the hallway and was not covered by a privacy bag. He confirmed urinary catheter drainage bags should be placed in privacy bags because an uncovered catheter drainage bag was a dignity and privacy issue for the resident. During an interview on 9/2/2026 at 12:40 PM, the DON stated the facility's expectation was for urinary catheter drainage bags to be covered by privacy bags. The DON confirmed that Resident #92's urinary catheter drainage bag, being uncovered and visible from the hallway, was a dignity issue. Record review of the "Face Sheet" revealed the facility admitted Resident #92 on 7/08/26 with medical diagnoses that included Heart Failure, and Retention of urine. Record review of the MDS with an ARD of 7/14/26, revealed under Section C a BIMS summary score of 09, which indicated Resident #92 has moderate cognitive impairment.			M0500			

Mississippi State Department of Health

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M0610	45.21.2 Activities of daily living Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well being. These shall include, but not be limited to: 1. Bath, dressing and grooming; 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4. Toileting. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on observations, interviews, record reviews and facility policy review, the facility failed to provide necessary personal hygiene and grooming services as evidenced by excessive facial hair (Resident #4 and Resident #52) and long fingernails (Resident #4, Resident #8, Resident #52 and Resident #58) for 4 (four) of 26 sampled residents. Findings include: Review of facility policy titled "Activities for Daily Living" with a revision date of 09/25 revealed, "Activities of Daily Living (ADL) shall be documented daily by the Certified Nurse Aide (CNA) or Nurse Aide Trainee (NAT) to reflect actual care rendered to the resident. 1. ...ADLs are to be resident specific and reflect current resident status. 2. ...ADLs shall include, but are not limited to personal hygiene, bathing..." Resident #4 Observations on 08/31/2026 at 12:20 PM and again on 09/01/2026 at 8:40 AM revealed Resident #4 lying in bed with her eyes closed. Resident #4 had an approximately 1/4-inch patch of thick white facial hair on her chin and approximately 1/4-inch-long fingernails with a brown substance underneath the nails. Resident #4 was bedbound and dependent on staff for ADL care. An interview on 08/31/2026 at 12:25 PM with Certified Nursing Assistant (CNA) #4 revealed the facility had two shower CNAs, one assigned to each side of the facility. CNA #4 stated residents in			M0610			

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M0610	Continued from page 6 odd-numbered rooms received showers/baths on Mondays, Wednesdays, and Fridays, and residents in even-numbered rooms received showers/baths on Tuesdays, Thursdays, and Saturdays. CNA #4 stated CNAs assigned to each hall were responsible for providing bed baths to their assigned residents. During a telephone interview on 09/01/2026 at 11:35 AM, Resident #4's Resident Representative (RR) stated she was not always pleased with the care facility staff provided. The RR stated she had reported to facility staff several times that Resident #4's facial hair was not being shaved and she continued to have to remind staff. The RR stated she had also observed Resident #4's fingernails to be dirty on several visits. The RR stated that during a visit over this past weekend, she observed Resident #4's facial hair and stated, "If you don't take care of this, I will." The RR stated Resident #4 was immobile and dependent on staff to provide her care. The RR further stated Resident #4 did not like having facial hair when she lived at home, that it was not right for staff not to keep her shaved and looking nice, and stated, "I want it off." An interview on 09/01/2026 at 2:05 PM with CNA #1 revealed Resident #4 should have been shaved on her scheduled bath day on Monday. CNA #1 confirmed Resident #4 had not been shaved the previous day. CNA #1 stated Resident #4's fingernails needed to be cut and cleaned and confirmed the substance underneath the resident's fingernails appeared to be dirt. CNA #1 stated nail care should be provided at least daily. An interview on 09/01/2026 at 2:30 PM with Licensed Practical Nurse (LPN) #2 revealed Resident #4 received a bed bath on Mondays, Wednesdays, and Fridays and shaving facial hair was included as part of the bath. LPN #2 confirmed Resident #4 had thick white facial hair and long, dirty fingernails. An interview on 09/01/2026 at 2:50 PM with the Director of Nursing (DON) revealed her expectation was for residents not to have unwanted facial hair and to have short, clean fingernails. The DON confirmed Resident #4 had thick white facial hair on her chin. A record review of the Quarterly Minimum Data Set Assessment (MDS), with an Assessment Reference Date (ARD) of 06/05/2026, revealed Functional Abilities self-care Section GG, personal hygiene coded as dependent. A record review of Face Sheet revealed that the			M0610			

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M0610	Continued from page 7 facility admitted Resident # 4 on 05/31/2022 with a diagnosis of Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. Resident #8 An observation on 08/31/2026 at 1:30 PM revealed Resident #8 had approximately 1/2-inch-long, jagged fingernails with a brown substance underneath the nails. A subsequent observation on 09/01/2026 at 8:50 AM revealed Resident #8 continued to have long, jagged fingernails with a brown substance underneath the nails. An interview on 09/01/2026 at 2:10 PM with LPN #5 revealed Resident #8's fingernails were long, dirty, and jagged. LPN #5 stated CNAs could cut residents' fingernails as long as the resident was not diabetic or receiving blood-thinning medication. LPN #5 stated Resident #8's fingernails had not been cut in a while and nail care triggered on the staff task list. LPN #5 confirmed long that jagged fingernails placed Resident #8 at risk of cutting herself or developing an infection. An interview on 09/01/2026 at 2:30 PM with the DON confirmed Resident #8's fingernails were long, dirty, and jagged. The DON stated Resident #8 could harm herself by getting cut. A record review of the Quarterly MDS, with an ARD of 7/22/2026, revealed Functional Abilities self-care Section GG, personal hygiene coded as substantial/maximal assistance. A record review of "Face Sheet" revealed that the facility admitted Resident #8 on 04/16/2024 with a diagnosis unspecified dementia, severe, with mood disturbance. Resident #52 An observation on 8/31/2026 at 4:35 PM revealed Resident #52 had facial hair to her chin area approximately one-half (1/2) inch long. Resident #52's bilateral fingernails were approximately one (1) inch long, jagged, and had a brown substance underneath the nails. Observations on 9/01/2026 at 8:45 AM and again at 3:05 PM revealed Resident #52's facial hair and fingernails remained unchanged from the previous day's observation.			M0610			

Mississippi State Department of Health

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M0610	Continued from page 8 During an interview and observation on 9/01/2026 at 3:30 PM, CNA #1 stated she was assigned to Resident #52 that day. CNA #1 stated shaving facial hair was performed as needed and fingernails were cleaned daily and as needed. CNA #1 stated she thought Resident #52 was diabetic and that nursing staff were responsible for trimming the resident's fingernails. CNA #1 confirmed Resident #52 had facial hair to her chin area and long, jagged fingernails. CNA #1 acknowledged Resident #52 should have already been appropriately groomed. During an interview and observation on 9/01/2026 at 3:40 PM, LPN #1 stated CNAs were responsible for trimming Resident #52's facial hair during daily personal care and nursing staff were responsible for trimming her fingernails because the resident was diabetic. LPN #1 stated shaving and nail trimming were performed as needed when staff noticed they needed to be done. LPN #1 confirmed Resident #52 had approximately one-half (1/2) inch of facial hair to her chin and fingernails that were long, jagged, and unkempt. LPN #1 stated, "Her nails really need to be cut, they are so long and she could scratch herself and create a skin tear and it could cause an infection." During an interview on 9/02/2026 at 3:09 PM, the DON stated the facility's expectation was for all residents to be adequately groomed. The DON stated CNAs were responsible for ensuring facial hair was shaved during personal hygiene care provided to the resident and that fingernails were to be trimmed and cleaned. Record review of the "Face Sheet" revealed Resident #52 was admitted to the facility on 2/21/25 with medical diagnoses that included Unspecified Dementia, Type 2 Diabetes Mellitus, and Pain. Record review of the MDS, with an ARD of 5/22/26, revealed a BIMS summary score of 02 under Section C, which indicated Resident #52 was severely cognitively impaired. Resident #58 An observation of Resident #58 on 8/31/26 at 1:10 PM revealed she was seated in her wheelchair with a splint on her right hand. The resident's fingernails were approximately one-fourth (1/4) to one-half (1/2) inch long on both hands, with the fingernails on the			M0610			

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M0610	Continued from page 9 right hand longer than those on the left hand. During an observation and interview with CNA #3 on 9/1/26 at 2:00 PM, he confirmed Resident #58 had long fingernails that needed to be cut. CNA #3 stated the nurses were responsible for cutting residents' fingernails. During an observation and interview with the DON on 9/1/26 at 2:15 PM, she stated nurse aides could cut the fingernails of residents who did not have diabetes and were not receiving a blood thinner. She stated Resident #58 was receiving a blood thinner; therefore, a nurse was responsible for cutting her fingernails. The DON stated the task was scheduled on an as-needed basis and did not alert the nurses at regular intervals. She confirmed Resident #58 was at risk for skin breakdown because she wore a splint for finger contractures and had long fingernails. Record review of the "Face Sheet" revealed Resident #58 was admitted to the facility on 9/23/24 with medical diagnoses that included Hemiplegia and Hemiparesis Following Unspecified Cerebrovascular Disease Affecting the Right Dominant Side and Contracture of the Muscles of the Right Hand. Record review of the MDS, with an ARD of 7/17/26, revealed a BIMS summary score of 15 under Section C, which indicated Resident #58 was cognitively intact. Section GG revealed the resident required substantial/maximal assistance with personal hygiene.	M0610			
M0625	45.21.5 Range of motion Range of motion. Residents with limited range of motion shall receive treatment and services to increase range of motion or prevent further decline in range of motion. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, staff and resident interview, record review, and facility policy review, the facility failed to ensure a resident with limited mobility received appropriate equipment to maintain mobility with the maximum practicable independence for one (1) of three (3) residents reviewed for range of motion. The facility failed to provide Resident #28 with a wheelchair of an appropriate height that allowed the resident to use her feet to assist with self-propulsion. Resident #28 was observed in a wheelchair without footrests with her feet unable to effectively reach the floor for self-propulsion. This	M0625			

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M0625	Continued from page 10 failure limited the resident's ability to independently propel herself throughout the facility. Findings Included: Record review of the facility policy, titled "Wheelchair, Use of," latest revision date 07/26 revealed, "The facility shall provide safe and comfortable mobility for the non-ambulatory resident and provide mobility for residents learning to become independent in activities of daily living..." On 08/31/2026 at 1:15 PM, Resident #28 was observed sitting in a wheelchair in the facility lobby. The wheelchair did not have footrests and was not the correct height to enable her feet to rest on the floor. Resident #28's bilateral feet were observed to be purple, with her left foot dangling free, and the great toe of her right foot was touching the floor. During an interview on 08/31/2026 at 3:25 PM, Resident #28 stated, "It takes me a long time to get where I am going because I am slow." Resident #28 further stated, "My room is three quarter a mile down that hall, so I have to start early to get somewhere." In an interview on 09/01/2026 at 8:45 AM, Resident #28 stated, "I have to use my hands because it takes more effort to scoot up to use my feet." She confirmed that the wheelchair needed to be shorter, so she did not have to scoot herself towards the front of the wheelchair for her feet to reach the floor. On 09/02/2026 at 8:34 AM, Resident #28 was observed sitting in her room in a wheelchair with footrests in place and both feet resting on the footrests. During an interview on 09/02/2026 at 8:35 AM, Licensed Practical Nurse (LPN) #5 stated Resident #28 used a wheelchair to move throughout the facility, could self-transfer and self-propel, and was able to use her feet to propel the wheelchair. LPN #5 stated Resident #28 was currently receiving therapy services and should have footrests on her wheelchair every day. During an interview on 09/02/2026 at 8:40 AM, Physical Therapist (PT) stated Resident #28 had been using another resident's custom wheelchair. The PT stated Resident #28 could propel herself using her feet and that a shorter wheelchair was being provided to the resident that day. The PT stated residents should be provided with a wheelchair that fits their needs. The PT further stated that if			M0625			

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 09/03/2026	
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M0625	Continued from page 11 Resident #28 was unable to use her feet, this could result in decreased leg strength, improper ankle positioning, and an inability to propel herself. The PT stated that if Resident #28 could use her feet to assist with propulsion, mobility would be easier for the resident. The PT further stated Resident #28 did not currently have a wheelchair mobility goal. During an interview on 09/02/2026 at 8:45 AM, the Director of Nursing (DON) stated Resident #28 was admitted to the facility in February 2026 and had used a wheelchair since admission. The DON stated Resident #28 propelled herself using her hands. The DON acknowledged Resident #28 should have footrests on the wheelchair to prevent her feet from "going to sleep" and agreed Resident #28 should be provided a wheelchair that fits her height so her feet could reach the floor. A record review of the Quarterly Minimum Data Set Assessment (MDS), with an Assessment Reference Date (ARD) of 05/15/2026, revealed a Brief Interview for Mentals Status (BIMS) score of 9 indicating that the resident has moderate cognitive impairment. MDS further revealed Mobility Devices used was a wheelchair in Section GG Functional Abilities. A record review of "Face Sheet" revealed that the facility admitted Resident #28 on 02/06/2026 with a diagnosis of Parkinson's disease without dyskinesia.			M0625			
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: Level III Past Non-Compliance Based on observation, interviews, record review, and policy review, the facility failed to ensure staff used the ordered stand-up lift during a transfer for one (1) of two (2) residents reviewed for accidents (Resident #31). This deficient practice resulted in Resident #31's left leg bending beneath the wheelchair and an acute nondisplaced fracture of the proximal tibia. Resident #31 experienced severe pain, required brace/cast for splinting, had a prolonged facility stay, and remained unable to walk.			M0640	"Past Noncompliance - no plan of correction required"		

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 09/03/2026	
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M0640	Continued from page 12 Based on the facility's implementation of corrective actions on 4/13/26, the State Agency (SA) determined the deficiency to be Past Non-Compliance and facility was in compliance as of 4/14/26, prior to the SA's entrance on 8/31/26. Findings Include: Review of the facility policy titled "Accident Prevention," revised 9/25, revealed, "Each resident shall receive adequate supervision and assistive devices to reduce the likelihood of accidents. The environment will be free from accident hazards for all residents, staff, and visitors through interventions such as but not limited to: 1. Safety devices used per policy..." Record review of the "Quarterly Lift/Transfer Assist Screening," dated 3/27/26, revealed Resident #31 was unable to bear weight and lacked the upper-extremity strength needed to support herself during transfers. The screening directed staff to use a stand-up lift with two staff members present. Record review of Resident #31's "Care Plan History," dated 9/26/25, revealed the resident was care planned for transfers using a sit-to-stand lift. Record review of the Facility Reported Incident (FRI) investigation, dated 4/14/26, revealed Resident #31 reported left leg pain on 4/11/26 after she was placed in her wheelchair. During an interview for the investigation, Resident #31 stated her leg struck the wheelchair. Due to continued uncontrolled pain, the resident was sent to the emergency department, where imaging confirmed an acute nondisplaced transverse fracture of the proximal tibial metaphysis. The FRI documented that video surveillance showed an aide taking a facility stand-up lift into Resident #31's room. The FRI further documented that Resident #31, and the aide reported the resident requested a manual transfer without use of the lift. Record review of Resident #31's "Incident Report," dated 4/13/26, revealed under "Nursing Description: Nurse was called this morning to resident's room to provide pain management, and resident stated an event that happened on the morning of 4/11/26. She informed that the reason she broke her leg was because she was lifted and placed in the wheelchair physically by the Certified Nursing Assistant (CNA), and the stand-up lift was not used..." Record review of Resident #31's "Emergency Department Consultation," dated 4/12/26, revealed under "Radiographic Studies:" a computed			M0640			

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 09/03/2026	
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M0640	Continued from page 13 tomography (CT) scan of the left lower extremity showed an acute nondisplaced transverse fracture of the proximal tibial metaphysis. During an observation and interview on 8/31/26 at 1:02 PM, Resident #31 was observed lying in bed. Resident #31 stated she sustained a left leg fracture after CNA #6 transferred her from the bed to a wheelchair without using the lift. The resident stated that previously the staff had always used a sit-to-stand lift. She explained that on the day of the incident, CNA #6 and CNA #7 entered her room to assist her out of bed and brought the lift into the room. Resident #31 stated that while she sat on the side of the bed, CNA #7 began taunting CNA #6 by stating, "You're so big and strong you can do it without the lift." The resident stated CNA #6 then grabbed her under the arms and placed her in the wheelchair. Her left leg bent backward beneath the wheelchair, and she heard a loud crack. She did not experience immediate pain, but severe pain developed later that day. She called her son and requested to go to the emergency department, where staff determined her leg was fractured. Resident #31 stated she wore a brace and then a cast for eight weeks. She explained the incident affected her emotionally and physically. She originally entered the facility for short-term therapy with the goal of returning home. Due to the incident, her stay was prolonged, she remained unable to walk, and she was unsure whether she would be able to return home. During an interview on 9/01/26 at 3:01 PM, Licensed Practical Nurse (LPN) #5 stated the incident occurred on a Saturday. LPN #5 stated CNA #6 provided Resident #31's morning care and transferred her alone without the ordered lift. Later that day, while LPN #5 made rounds, Resident #31 reported she had bumped her leg and it was hurting. LPN #5 administered pain medication, and the resident was transferred to the emergency department during the following shift due to uncontrolled pain. LPN #5 stated she did not question CNA #6 at that time because the resident had not reported that the aide transferred her without the lift. Record review of the personnel record revealed CNA #6 received education regarding lift procedures on 4/17/25. An interview with the Director of Nursing (DON) on 9/01/26 at 3:11 PM revealed Resident #31 did not initially tell staff that CNA #6 transferred her without the lift. The DON stated that on the following Monday morning, after the resident returned from the			M0640			

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 09/03/2026	
NAME OF PROVIDER OR SUPPLIER HIGHLAND HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 638 HIGHLAND COLONY PARKWAY , RIDGELAND, Mississippi, 39157			
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M0640	Continued from page 14 hospital, she spoke with the resident and learned of the manual transfer. During an interview with the Administrator (ADM) and DON on 9/02/26 at 8:58 AM, the ADM stated CNA #6 and CNA #7 took the sit-to-stand lift into the room. She explained CNA #7 was providing care to Resident #31's roommate. According to the DON, Resident #31 and CNA #6 reported during the facility investigation that the resident refused use of the lift and requested a manual transfer. The ADM stated CNA #7 was in the room, was interviewed, and provided a written statement that she did not witness the transfer. The DON and ADM confirmed Resident #31 should not have been manually transferred, and the nurse should have been notified. The ADM stated CNA #6 was terminated for failing to follow the facility's lift policy, and CNA #7 received disciplinary action for failing to report the incident. The ADM stated CNA #7 no longer worked at the facility. Record review of the "Face Sheet" revealed the facility admitted Resident #31 on 6/24/25 with medical diagnoses that included Parkinson's disease without dyskinesia, personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits. Record review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 3/27/26, revealed under Section C a Brief Interview for Mental Status (BIMS) summary score of 15, which indicated Resident #31 was cognitively intact. Review of the facility's corrective-action documentation and an interview with the DON on 9/02/26 at 10:11 AM revealed the facility implemented the following actions to correct the deficient practice: On 4/13/26, the facility terminated CNA #6, who manually transferred Resident #31 without the ordered lift. On 4/13/26, the facility disciplined CNA #7 for failing to report the incident. On 4/13/26, the facility completed an all-staff in-service regarding lift transfers. The in-service included Seven Components to Reduce, Detect, and Prevent Abuse and Neglect; Resident Rights; Abuse and Neglect; Vulnerable Adult Act; Mechanical Lift; and the facility's Lift Policy. On 4/13/26, the DON, Assistant Director of Nursing,			M0640			

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 09/03/2026	
NAME OF PROVIDER OR SUPPLIER HIGHLAND HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 638 HIGHLAND COLONY PARKWAY , RIDGELAND, Mississippi, 39157			
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M0640	Continued from page 15 Minimum Data Set team, and medical records employee completed a 100% audit of lift tasks, orders, care plans, and in-room lift identification. On 4/13/26, assigned nurses and the Registered Nurse supervisor completed a 100% body audit of all residents for evidence of abuse, neglect, or new skin injuries and reported the findings to the DON. Beginning 4/13/26, the facility scheduled an abuse drill for each shift. On 4/13/26, the facility held an emergency Quality Assurance (QA) meeting with the Medical Director. On 4/13/26, the facility initiated a four-week Performance Improvement Project (PIP) regarding proper lift transfers. The PIP included observation of ten residents per shift each week who had varying lift-transfer needs. On 4/13/26, the facility initiated ongoing monitoring through QA meetings for two months, followed by quarterly review, to sustain compliance. The SA validated on 9/2/26, through interview and record review that all corrective actions had been implemented as of 4/13/26, and the facility was in compliance as of 4/14/26, prior to the SA's entrance on 8/31/26.			M0640			
M0715	45.24.4 Labeling of drugs Labeling of drugs. Each facility shall follow the Mississippi State Board of Pharmacy labeling requirements. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on observation, record review, staff interviews, and facility policy review, the facility failed to: 1) secure a medication cart and a prepared medication syringe from unauthorized access when unattended for one (1) of four (4) medication carts observed. The unattended syringe contained heparin prepared for Resident #117; and 2) identify and resolve discrepancies between current physician orders and pharmacy dispensing labels for two (2) of seven (7) residents observed for medication administration; Residents #24 and Resident #48. Findings include:			M0715			

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 09/03/2026	
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M0715	Continued from page 16 Review of the facility policy titled "Medication Ordering, Reordering and Receiving Procedures," with a latest revision date of 12/2019, revealed, "...compare each medication received to what was ordered, ensuring the resident name, medication, dose, route and frequency are correct...The pharmacy is to be notified for discrepancies..." Review of the facility policy titled "Drug Administration and Documentation," with a latest review date of 3/2025, revealed, "...The medication cart is...to be locked whenever unattended. Do not leave ANY medications on top of the medication cart unattended..." Medication Cart During an observation on 9/2/2026 at 6:08 AM, the medication cart on the 600 Hall was unlocked and unattended. A capped 1-milliliter syringe containing a clear liquid was observed unattended on top of the medication cart. During an interview on 9/2/2026 at 6:10 AM, Licensed Practical Nurse (LPN) #4 confirmed she had stepped away from the medication cart and left it unlocked and unattended. LPN #4 also confirmed the syringe contained heparin and was prepared for Resident #117. Record review of Resident #117's Order Summary Report revealed an active order dated 8/24/2026 for heparin sodium injection, 5,000 units per milliliter, to inject 1.5 milliliters subcutaneously three times daily for 14 days. Each dose was to equal 7,500 units. During an interview on 9/2/2026 at 6:40 AM, the Director of Nursing (DON) confirmed a medication cart should never be left unlocked when unattended and medications should not be left unattended. Record review of Resident #117's "Face Sheet" revealed the resident was admitted to the facility on 8/24/26 with medical diagnoses that included heart failure, unspecified. Record review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 8/31/26, revealed a Brief Interview for Mental Status (BIMS) summary score of 14 under Section C, which indicated Resident #117 was cognitively intact. Resident #24 During an observation of medication administration for Resident #24 on 9/2/2026 at 7:00 AM, record			M0715			

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 09/03/2026	
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M0715	Continued from page 17 review of the resident's Order Summary Report revealed an active order dated 8/3/2026 for hydrocodone-acetaminophen 7.5-325 milligrams, one tablet by mouth three times daily for pain. Review of the pharmacy label on Resident #24's medication card directed staff to administer one tablet by mouth every eight hours as needed for pain. The pharmacy label did not match the current physician order because the physician order scheduled the medication three times daily, while the pharmacy label identified the medication as an as-needed medication. During an interview on 9/2/2026 at 7:00 AM, LPN #3 confirmed the pharmacy label did not match the physician order. LPN #3 stated the medication card had been labeled that way for approximately two weeks, which was as long as she had worked at the facility. LPN #3 stated that at her previous place of employment, the nurse was required to notify the pharmacy and obtain a corrected label, but she was uncertain how medication-label discrepancies were handled at this facility. During an interview on 9/2/2026 at 7:25 AM, the DON confirmed the pharmacy label did not match Resident #24's physician order. The DON stated the nurse should have notified the pharmacy, faxed the order to the pharmacy, and obtained a change-in-order label to attach to the medication card. Record review of Resident #24's "Face Sheet" revealed the resident was admitted to the facility on 4/12/24 with medical diagnoses that included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Record review of the MDS, with an ARD of 7/10/26, revealed a BIMS summary score of 02 under Section C, which indicated Resident #24 had severe cognitive impairment. Resident #48 During an observation of medication administration for Resident #48 on 9/2/2026 at 2:12 PM, record review of the resident's Order Summary Report revealed an active order dated 4/16/2026 for fluoxetine 20 milligrams, administer one-half tablet by mouth each morning for withdrawn behavior related to major depressive disorder. Review of the medication supplied by the pharmacy revealed fluoxetine 10-milligram tablets. The pharmacy label directed staff to administer one tablet by mouth each			M0715			

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 09/03/2026	
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M0715	Continued from page 18 morning. Although both directions resulted in a 10-milligram dose, the medication strength and administration instructions on the pharmacy label did not match the current physician order. During an interview with LPN #2, she stated, "It says on the card for each dose to equal 10 milligrams." During an interview on 9/2/2026 at 10:45 AM, the DON confirmed the nurse should have contacted the physician to obtain an order that matched the medication strength and administration directions supplied by the pharmacy. Record review of Resident #48's "Face Sheet" revealed the resident was admitted to the facility on 1/30/25 with medical diagnoses that included unspecified dementia, moderate, with mood disturbance. Record review of the MDS, with an ARD of 7/31/26, revealed a BIMS summary score of 03 under Section C, which indicated Resident #48 had severe cognitive impairment.			M0715			
M0780	45.27.2 Activity Program Activity Program. Provisions shall be made for suitable recreational and entertainment activities for resident according to their needs and interests. These activities are an important adjunct to daily living and are to encourage restoration to self-care and resumption of normal activities. Variety in planning shall include some outdoor activities in suitable weather. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on record review, facility policy review, resident interviews, and staff interviews, the facility failed to provide an ongoing program of activities designed to meet the individualized interests and physical, mental, and psychosocial needs of one (1) of 26 sampled residents reviewed. Resident #112 Findings included: Review of the facility's policy titled "Activity Programs & Activity Programs Scheduling," with a revision date of 11/2017, revealed "Policy: Activity Program, The facility will provide an ongoing program of age-appropriate activities designed to meet, in accordance with the comprehensive assessment, the interests and physical, mental, and psychosocial needs of each resident... Procedures:			M0780			

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 09/03/2026	
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M0780	Continued from page 19 7. Residents in isolation will be provided with access to independent activities as their medical condition allows..." Record review of the Order Summary Report with an order dated 8/25/26 revealed Resident #112 was on contact isolation precautions related to a Staphylococcus infection of a chest wall surgical incision. Review of Resident #112's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) dated 8/31/2026 in "Section F. Preferences for Customary Routine and Activities," revealed the resident was the primary respondent for the assessment. The resident identified having books, newspapers, and magazines to read; listening to music she liked; keeping up with the news; doing things with groups of people; doing her favorite activities; and going outside for fresh air when the weather was good as somewhat important. The resident identified participating in religious services or practices as very important. During an interview on 08/31/2026 at 4:30 PM, Resident #112 stated she wanted to come out of her room and would not have come to the facility if she had known she was "banned from everything." Resident #112 stated that shortly after she arrived at the facility, she came out of her room, and a staff member told her she could not be out and instructed her to return to her room. During a follow-up interview on 09/02/2026 at 2:30 PM, Resident #112 stated no one had been in to provide activities, and she was not able to leave her room. Resident #112 stated therapy had come into her room twice, but no one else came in to provide activities. The resident stated she was unhappy because she was unable to talk with other people. She also stated no one told her she was in contact isolation and she thought the supplies on the door were housekeeping supplies. During an interview with the Activities Director on 9/02/2026 at 2:55 PM, the Activities Director stated she assessed Resident #112 on 08/31/2026 and asked the resident if she wanted to attend church activities, and that she could attend church services, but she was unaware she was on contact isolation. During an interview on 09/03/2026 at 10:00 AM, the Director of Nursing (DON) stated she was unaware Resident #112 had not received any activities. She stated she had been in the facility before and remembered she liked to sit on the porch.			M0780			

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 09/03/2026	
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M0780	Continued from page 20 Record review of the "Face Sheet" revealed the facility admitted Resident #112 on 8/25/2026 with medical diagnoses that included Disruption of Wound and Staphylococcus. Record review of the MDS with an ARD of 8/31/2026, revealed under Section C a BIMS summary score of 15 indicating Resident #112 is cognitively intact.			M0780			
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: Level II Based on observation, record review, policy review, and interviews, the facility failed to establish and implement infection prevention and control practices to prevent the potential transmission of infection and failed to ensure clean linens were maintained in a sanitary manner. Specifically, the facility failed to implement Enhanced Barrier Precautions (EBP) and appropriately handle contaminated linens during catheter care for Resident #2, store respiratory equipment in a sanitary manner for Resident #3 and ensure linens			M1570			

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 09/03/2026	
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
M1570	Continued from page 21 that fell onto the floor were removed from the clean-linen supply and placed with soiled/dirty laundry, for three (3) of four (4) days of survey. Findings include: Review of the facility's policy titled "General Infection Prevention and Control Nursing Policies," dated 06/2014, 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..." Review of the facility's policy titled "Infection Control Oxygen Equipment Cleaning," revised 08/21, revealed "...10. When not in use, store the mask/cannula in a plastic bag clearly labeled with the resident's name and date..." Record review of the facility policy, titled "Enhanced Barrier Precautions", revised 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..." Resident #2 On 09/02/2026 at 10:50 AM, an observation was conducted of Certified Nursing Assistant (CNA) #3 providing catheter care to Resident #2. CNA #3 cleaned Resident #2's foley catheter tubing and discarded the soiled washcloth onto the floor. CNA #3 did not wear a gown while providing catheter care. Dirty linen was also observed on the floor upon entering Resident #2's room. During the provision of catheter care, CNA #3 placed a second soiled washcloth on the resident's overbed table instead of containing the contaminated linen in a bag. During an interview on 09/02/2026 at 11:00 AM, CNA #3 verified that a gown should have been worn while providing catheter care and that dirty linen should not have been placed on the floor or the resident's overbed table. CNA #3 stated she should have worn a gown during the catheter care and should have placed the dirty linen and soiled bath cloths in a bag. During an interview on 09/02/2026 at 4:30 PM, the			M1570			

Mississippi State Department of Health

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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
M1570	Continued from page 22 Infection Preventionist (IP) stated the expectation was for staff to implement Enhanced Barrier Precautions during catheter care. The IP stated EBP was used to protect against the transfer of bacteria between residents and staff and stated dirty linen should be placed in a bag. During an interview on 09/02/2026 at 5:00 PM, the Director of Nursing (DON) stated the expectation was for staff to wear a gown and gloves during catheter care and that dirty linen should be placed in a bag to prevent contamination and the spread of infection . A record review of the Quarterly Minimum Data Set Assessment (MDS), with an Assessment Reference Date (ARD) of 07/31/2026, revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating that the resident is cognitively intact. MDS further indicated in Section H Bladder and Bowel resident had an indwelling catheter. A record review of Face Sheet revealed that the facility admitted Resident #2 on 06/09/2022 with a diagnosis of Pressure ulcer of sacral region, Stage 4. Resident #3 Record review of the Order Summary revealed Resident #3 had a physician's order to apply Bilevel Positive Airway Pressure (BiPAP) with settings of 20/12 every night and to fill the tank to the appropriate level with distilled water prior to use. The order indicated the BiPAP was related to a diagnosis of obstructive sleep apnea. During an observation on 08/31/2026 at 10:45 AM, Resident #3's BiPAP mask was observed on the floor and did not have a protective covering. During a subsequent observation on 09/01/2026 at 2:44 PM, Resident #3's BiPAP mask was observed on the resident's nightstand and was not stored in a protective bag. During an observation and interview on 09/01/2026 at 2:59 PM, the DON stated BiPAP masks should be cleaned, dried, and then placed in a bag. The DON confirmed Resident #3's BiPAP mask was not stored in a bag and stated it was the facility's expectation that the mask be cleaned and stored in this manner to reduce the risk of respiratory infection. Record review of the "Face Sheet" revealed the facility admitted Resident #3 on 6/15/2026 with			M1570			

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M1570	Continued from page 23 medical diagnoses that included Obstructive Sleep Apnea, Methicillin Resistant Staphylococcus Aureus Infection, and Paraplegia. Record review of the MDS, with an ARD of 6/22/2026, revealed under Section C a BIMS summary score of 15 indicating Resident #3 is cognitively intact. Clean Linen Handling During an observation on 09/02/2026 at 9:17 AM, Housekeeper #1 was observed removing and handling clean linens from a clean-linen cart, when it was observed that clean linens fell from the cart onto the floor. Housekeeper #1 picked the linens up from the floor and returned them to the bottom of the clean-linen cart rather than placing them with the soiled/dirty laundry. During an interview on 09/02/2026 at 9:18 AM, Housekeeper #1 confirmed she returned the linens that had fallen onto the floor to the bottom of the clean-linen cart. The staff member stated, "It's only my second time to do laundry. I put it on the bottom. I thought it was okay." During an interview on 09/02/2026 at 1:30 PM, the DON confirmed the housekeeping staff member should have placed the linens that fell onto the floor into the dirty-laundry bin to help prevent the spread of infection.			M1570			