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	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Home	638 Highland Colony Parkway Ridgeland, MS 39157

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46013 Based on staff interview, record review and facility policy review, the facility failed to transmit a discharge Minimum Data Set (MDS) Assessment for one (1) of three (3) residents reviewed for discharge MDS assessments. Resident #90 Findings include: Review of the facility policy titled, MDS Process with a revision date of 12/20 revealed, The Assessment Nurse/Nurse Case Manager will set the Assessment Reference Date (ARD) on an allowable date with input from the interdisciplinary team and communicate scheduled assessments to the interdisciplinary team. The RAI (Resident Assessment Instrument) manual is the source document to be used for further MDS coding guidelines, time schedules and requirements. Record review of Resident #90's Face Sheet revealed an admitted [DATE] and a discharge date of [DATE] with a return not anticipated. During an interview on 6/19/24 at 10:05 AM, the MDS Nurse confirmed Resident #90 was admitted to the facility on [DATE] and discharged on [DATE]. She confirmed his discharge MDS was not completed and submitted and is now over 120 days late. She revealed this was omitted in error and has not been completed.

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46013 Based on observation, staff and resident interview, record review, and facility policy review the facility failed to implement care plans for a resident's Activities of Daily Living (ADL) care and a resident's pain medication management for two (2) of 18 resident care plans reviewed. Resident #14 and Resident #53 Findings include: Record review of facility policy titled, Care Plan Process, dated 8/17, revealed, Regulations require facilities to complete, at a minimum and at regular intervals, a comprehensive, standardized assessment of each resident's functional capacity and needs, in relation to a number of specified areas. The results of the assessment, which must accurately reflect the resident's status and needs, are to be used to develop, review, and revise each resident's comprehensive person-centered plan of care. The care plan is driven not only by identified resident issues and/or conditions but also by a resident's unique characteristics, strengths, and needs. A care plan that is based on a thorough assessment, effective clinical decision making, and is compatible with current standards of clinical practice can provide a strong basis for optimal approaches to quality of care and quality of life needs of individual residents. The policy also revealed, The Physician Orders, Medication Administration Record, and Treatment Administration Record are part of the Comprehensive Care Plan. Resident #14 A record review of Resident #14's comprehensive care plan revealed the resident needs assistance with ADL's. Approaches: Assist with ADLs as needed. On 6/17/24 at 12:59 PM, observation and interview with Resident #14 revealed facial hair approximately one-half (1/2) inch to the sides of his cheeks, above his lip, and on his chin and neck. Resident #14's fingernails on bilateral hands were approximately 1/2 inch long and jagged with a brown substance under his nails. The resident stated it's been a long time since he was shaved, and he would like to be shaved and have his nails cut. An interview on 6/18/24 at 3:05 PM, the Assistant Director of Nurses (ADON) confirmed that male residents should be shaven, and all residents' nails cleaned and trimmed. The ADON confirmed Resident #14 care plan was not being followed regarding his ADL care. During an interview on 6/19/24 at 10:25 AM the Minimum Data Set (MDS) nurse revealed she and the MDS Assessment nurses are responsible for developing the resident's care plans and they are developed so the staff will know the resident's needs and how they are to be taken care of. She revealed personal hygiene includes shaving and nail care and it is a standard practice and the Certified Nursing Assistants (CNA) know that. She confirmed if Resident #14 was not shaved, and his nails were not taken care of then the plan of care for his ADL's was not followed. Record review of Resident #14's Face Sheet revealed the resident was admitted to the facility on [DATE] with medical diagnoses that included Shortness of breath and Muscle Weakness. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	41878 Resident #53 Record review of Resident #53's Care Plan revealed a problem/need dated 5/1/24 Resident is at risk for pain. The goal listed for this problem was Resident will have a decrease in pain through next review. Intervention listed as Administer meds as ordered. During an interview on 6/17/24 at 11:55 AM, Resident #53 revealed he had back and joint pain and took prescription pain medication two times a day for comfort and pain relief. He revealed a few weeks ago, the facility was out of his pain medications and he was given an over the counter pain medication which did not help relieve pain as well as the prescribed pain medication. During an interview on 6/19/24 at 9:10 AM, the Director of Nursing (DON) confirmed care plans are developed to guide the staff of the needed care for each resident. She confirmed Resident #53's pain care plan was not followed since the prescription medication for pain relief was not available to be given as ordered. She confirmed there was a documented pain level of ten (10) on the vital sign record dated 5/29/24 at 7:29 AM, and no interventions were documented as given. She confirmed that by the facility not having ordered pain medication, it was not readily available for this resident. She stated the facility failed to follow his developed comprehensive care plan concerning pain management. During an interview on 6/19/24 at 10:19 AM, the MDS Nurse confirmed the facility failed to follow Resident #53's comprehensive care plan for pain management. Record review of Resident #53's Face Sheet revealed he was admitted to the facility on [DATE] with diagnoses including Pain. Record review of MDS with Assessment Reference Date (ARD) of 4/30/24, revealed Resident #53 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46013 Based on observations, staff and resident interviews, record review, and facility policy review, the facility failed to ensure a resident who required assistance with Activities of Daily Living (ADLs) was assisted with personal hygiene as evidenced by long, jagged nails with brown substance underneath nails and unshaven facial hair for one (1) of three (3) residents reviewed for ADLs. Resident #14 Findings include: Record review of the facility policy titled, Shaving with a revision date of 01/24 revealed Purpose: To provide hygiene in accordance with the resident's preferences and preferred self-image. To provide for the resident's comfort. Record review of the facility policy titled, Nail Care with the latest review date of 01/24, revealed Purpose: To promote cleanliness, safety and a neat appearance. An observation and interview on 6/17/24 at 12:59 PM revealed Resident #14 sitting in his wheelchair, facial hair approximately one-half (1/2) inch to the sides of his cheeks, above his lip, and on his chin and neck. Resident #14's fingernails on bilateral hands were approximately 1/2 inch long and jagged with a brown substance under his nails. The resident revealed it's been a long time since he was shaved, and he would like to be shaved and his nails cut. An observation on 6/18/24 at 8:56 AM, and again at 1:00 PM, revealed Resident #14's appearance remained unchanged from the previous day. During an interview on 6/18/24 at 2:10 PM, Certified Nurse Aide (CNA) #1 revealed she is assigned to Resident #14 today and usually works the hall that he is on. She confirmed the resident gets his showers on Monday, Wednesday, and Fridays and gets a bed bath the other days. She revealed the showers and bed baths include shaving and nail care if the resident is not a diabetic. CNA #1 stated, To be honest with you, I don't know if the resident is diabetic. I have never shaved him or done his nailcare. An interview and observation on 6/18/24 at 2:35 PM, Licensed Practical Nurse (LPN) #1 revealed Resident #14 is not a diabetic and the CNAs are responsible for shaving him and doing his nail care. She confirmed the resident needed to be shaved and his nails were long and jagged. She confirmed with his long fingernails that he could scratch his skin and cause a skin tear. In an interview on 6/18/24 at 3:05 PM, the Assistant Director of Nurses (ADON) confirmed the male residents should be shaved and all residents' nails cleaned and trimmed. Record review of Resident #14's Face Sheet revealed the resident was admitted to the facility on [DATE] with medical diagnoses that included Shortness of breath and Muscle Weakness.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 47874 Based on observation, resident and staff interview, record review, and facility policy review, the facility failed to label and store an aerosol nebulizer mask in a manner that prevented possible contamination of the device for one (1) of 27 nebulizers in the facility. Resident #98 Findings Include: Record review of the facility policy titled Infection Control Oxygen Equipment Cleaning with a revision date of 8/2021 revealed when not in use, store the mask/cannula in a plastic bag clearly labeled with the resident's name and date. An observation and interview with Resident #98 on 6/17/2024 at 12:39 PM, revealed a nebulizer machine was sitting on the bedside dresser, with an unbagged and undated nebulizer mask and tubing lying on top of the machine. The resident revealed she did use the mask, but she was unsure how often. An observation on 6/18/2024 at 2:08 PM, of Resident #98's room, revealed a nebulizer machine sitting on the bedside dresser with an unbagged and undated nebulizer mask and tubing draped over the machine. Record review of Resident #98's June 2024 Medication Administration Record (MAR) revealed an order dated 2/1/2024, Ipratropium 0.5 mg (milligram)-albuterol 3 mg (milligrams) (2.5 mg [milligram] base)/3 ml (milliliter) nebulization soln (solution): Give 3 milliliter(s) using nebulizer four times daily. An interview with Licensed Practical Nurse (LPN) #2 on 6/18/2024 at 2:16 PM, revealed Resident #98 did use the nebulizer machine daily. She revealed the nebulizer tubing and mask usually have a date on it. She confirmed she was responsible for ensuring the nebulizer mask was placed back in a bag and that the tubing was dated. An interview with the Director of Nursing (DON) on 6/18/2024 10:55 AM, confirmed the nebulizer mask should be dated. She stated they change out the mask and tubing every week on Tuesday and a date should be placed on the mask and tubing at that time. Record review of the Face Sheet revealed the facility admitted Resident #98 on 2/1/2024 with medical diagnoses which included Aftercare following joint replacement surgery and Unspecified Dementia.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41878 Based on staff and resident interview, record review, and facility policy review, the facility failed to ensure a resident was free of pain for one (1) of three (3) residents reviewed for pain. Resident #53 Findings include: Record review of facility policy titled, Pain Screen and Management, dated 12/23 revealed, All residents have the right to treatment for pain. Resident preferences are respected when deciding on methods to be used for pain management. Family members are involved when appropriate. The resident's statements are the most valid measurement of pain. Record review of facility policy titled, Medication Ordering, Reordering and Receiving Procedures, dated 12/19, revealed, Reordering Medications . On the established medication check day, the 11-7 (10-6) nurse will check all medications, not just punch cards, and reorder any medications that need to be re-filled. At the end of the shift, after all medications have been checked, the reorder will be faxed to the appropriate pharmacy. A form will be retained in the medication order/reorder binder with the fax confirmation. Checking in Medication Received from the pharmacy via courier. 1. Using the Medication Order/Re-Order Form for re-orders and New Medication Reconciliation form for new orders, compare each medication received to what was ordered, ensuring the resident name, medication, dose, route and frequency are correct. As each medication is checked, nurse places initials and amount received in the column to verify the reconciliation. The pharmacy is to be notified for discrepancies. During interviews with Resident #53 on 6/17/24 at 11:55 AM, and 6/18/24 at 3:30 PM, he stated he had back and joint pain and received prescription pain medication each morning and night to control his pain. He stated several weeks ago the facility did not have his prescription pain medication available, so he was given over the counter medication for his pain control, but that did not completely ease his pain. During an interview on 6/18/24 at 9:45 AM, the Director of Nursing (DON) confirmed the facility ran out of Resident #53's prescription pain medication. She stated the facility's procedure when the resident was running low on pain medication, was to place the reorder sticker from the medication card to the pharmacy form and it would be scanned to the pharmacy. At that point, the pharmacy would review the information and decide if a prescription was needed, and notify the facility or the provider to obtain a prescription. She stated for Resident #53's pain medication, there was a failure in this process and the scanned request was not followed up on by the facility. She stated the resident was given over the counter pain medication and it was documented that it was effective for his pain control. She stated for situations like this, the nurse should notify the on call provider for a now dose order, and obtain the medication from the facility's emergency kit to administer to the resident for pain relief and this was not done. She stated if notified, the provider would send a prescription to the pharmacy and pharmacy would have delivered the medication day or night, but this was also not done. She stated the resident was out of his medication from the evening of 5/27/24 until evening of 5/30/24, when she returned to work and identified the concern. The Nurse Practitioner was notified, a prescription was obtained, and the medication was delivered right away. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	An interview on 6/18/24 at 1:30 PM, with the Nurse Practitioner (NP) revealed he was notified on 5/29/24 of Resident #53's complaints of pain and withdrawal type symptoms from not receiving his pain medication. When he assessed the resident, he stated his pain was well controlled and clinically, the resident did not exhibit any signs or symptoms of withdrawal. The NP stated that Resident #53 had received Tylenol and it was documented that the medication was effective, and the resident did not verbalize otherwise. He confirmed by his oversight, he failed to provide a prescription to obtain an ordered medication needed for the resident's pain control. During a phone interview on 6/18/24 at 2:15 PM, Licensed Practical Nurse (LPN) #3 revealed the resident's pain medication had been requested but was not delivered to the facility from the pharmacy so he did not have this medication available when needed. She stated she was uncertain of the date but she worked that night and the resident slept well and that next morning he complained of pain and requested his pain medication. She revealed the resident had an order for a prescription pain medication that he could take every eight hours if needed for pain and he would always take one in the morning and one in the evening for his pain management. Since that was unavailable she gave him an over the counter medication to help with his pain but he was not very happy that he did not receive his prescription medication. She stated the resident was concerned about withdrawals and she assessed the resident and he did not have a tremor, vomiting, or any other symptoms of withdrawal. She stated this occurred during the morning shift change and she notified the oncoming nurse to get his meds from the pharmacy when they opened so he would have them available when needed. She stated she did not notify the provider. During a phone interview on 6/18/24 at 4:40 PM, the Registered Pharmacist stated the pharmacy received the faxed medication request from the facility on 5/23/24. This was somehow overlooked, so the pharmacy staff did not follow-up with the provider or the facility. She confirmed it was the responsibility of both the pharmacy and facility to ensure the requests are addressed and since the provider was in the facility almost daily, the prescription should have been obtained from the facility and faxed to the pharmacy. She stated the facility did not notify the pharmacy until 5/30/24 when the prescription was received by the pharmacy and was filled that day and sent out for delivery that evening. She confirmed the oversight led to a delay in resident receiving his medication. An interview with the DON on 6/19/24 at 9:10 AM, revealed the facility failed to have an ordered as-needed (PRN) pain medication available for a resident that experienced frequent pain. She confirmed there was a documented pain level of nine (9) on the vital signs record dated 5/28/24 at 7:38 AM and Acetaminophen was given and documented as effective. She confirmed there was a documented pain level of ten (10) on the vital sign record dated 5/29/24 at 7:29 AM, and no interventions were documented as given. She confirmed the facility failed to administer medication or additional interventions to assist this resident with his pain management. She confirmed the facility failed to ensure his ordered medications were available. She confirmed the facility failed to provided adequate pain management care to a resident with frequent complaints of pain. Record review of Physician Orders revealed orders dated 4/24/24 for Hydrocodone 5 mg (milligrams) - Acetaminophen 325 mg tablet: Give one tablet orally every 8 hours as needed and Acetaminophen 325 mg tablet: Give 2 tablets orally (650 mg total dose) every 6 hours as needed. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #53's Electronic Medication Administration Record (EMAR) revealed on 5/28/24 at 7:39 AM Acetaminophen 325 mg (milligram) tablet - 2 tablets were given for a pain level of 9. The EMAR follow up note for Acetaminophen dated 5/28/24 at 9:20 AM, revealed, Medication was effective. Record review of the Vital Signs Grid for resident revealed on 5/28/24 at 7:38 AM Resident #53 was noted to have a verbal pain scale of 9. Review revealed on 5/29/24 at 7:29 AM, the verbal pain scale was listed as 10. Record review of Medication Reorders form dated 5/23/24, revealed Resident #53's reorder for prescription pain medication was sent to the pharmacy. Record review of a prescription for the pain medication Hydrocodone-APAP 5-325 mg tablet for Resident #53 was faxed to the pharmacy on 5/30/24. Record review of Progress Note dated 5/29/24 at 7:33 AM by LPN #3 revealed, Resident is out of Norco which he requests twice a day for joint pain since 5/27/24 at bedtime. He told CNA that he needed saltine crackers to counter act withdrawal. Record review of Resident #53's Face Sheet revealed he was admitted to the facility on [DATE] with diagnoses including Pain. Record review of the Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 4/30/24, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47874 Based on observation, staff interview, and facility policy review, the facility failed to store controlled substances in a permanently affixed locked compartment inside the refrigerator for one (1) of two (2) medication storage rooms observed. Findings Include: Review of the facility policy titled Controlled Drug Emergency Safe Protocol with a revision date of 6/17 revealed, Protocol: . Refrigerated controlled substances will be kept in a refrigerator lock box with the key stored in the Controlled Drug Emergency Safe. An observation of medication storage room [ROOM NUMBER], on 6/19/2024 at 8:16 AM, revealed a small black refrigerator that contained a large tan lock box with four (4) boxes of liquid lorazepam concentrate. The refrigerator also held a small clear box that contained three (3) injectable vials of lorazepam, which was secured with a yellow sealed tab. Both boxes were not permanently affixed and could be picked up and removed from the refrigerator. An interview on 6/19/2024 at 8:19 AM, with Licensed Practical Nurse (LPN) #1, revealed the tan and clear lock boxes were for the storage of controlled drugs that must be refrigerated. She confirmed the boxes contained lorazepam and were not permanently affixed, which could result in someone removing the boxes. An interview with the Director of Nursing (DON) on 6/19/2024 at 9:20 AM, confirmed the lock boxes were not permanently affixed and acknowledged that it should be to ensure the safety of the controlled drugs.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41878 Based on staff interview, record review, and facility policy review, the facility failed to accurately document the administration of the prn (as needed) pain medication in the electronic medication system for one (1) of three (3) residents reviewed for pain. Resident #53 Findings include: Record review of facility policy titled, Drug Administration and Documentation, dated 12/23, revealed, The complete act of administration entails removing an individual dose from a previously dispensed, properly labeled container (including a unit dose container), verifying it with the physician's orders, giving the individual dose to the proper resident, and promptly recording the time and dose given. The policy also revealed, Chart each resident's medications on the MAR (Medication Administration Record) immediately after it is administered, as well as any administration special requirements as they are obtained, and any refused or withheld medication. PRN (as needed) medications will be documented on the MAR and the reason for giving as well as the result/response for each dose given will be noted in the clinical record. Record review of facility policy titled, Pain Screen and Management, dated 12/23, revealed, When the resident is medicated with prescribed medication or treated as ordered, documentation of medication or treatment is done on the electronic Medication Administration Record (eMAR) or the electronic Treatment Administration Record (eTAR). The policy also revealed, The eMar will reflect resident usage of medication as a treatment modality and screening is completed on admission/readmission and in the observation period of each MDS. Documentation requirements for chronic pain management focus on the following: eMAR documentation, use of as needed (PRN) medication, review and revision of care plan as appropriate. Record review of Resident #53's Individual Resident Narcotic Record from 4/25/24 - 6/18/24 revealed 98 doses of his prescription pain medications were used from his medication supply cards received from pharmacy. Record review and comparison of the eMAR and the Individual Resident Narcotic Record for Resident #53 revealed 47 of these 98 doses were not documented in his eMAR. During an interview with the Director of Nursing (DON) and the Administrator on 6/19/24 at 9:10 AM, the DON revealed the Electronic Medication Administration Record (eMAR) did not accurately reflect the medications Resident #53 received according to the Individual Resident Narcotic Record. She confirmed the narcotic record revealed the resident received his narcotic pain medication two times a day, but the EMAR did not reflect this. The Administrator confirmed that it was unacceptable that out of approximately 98 doses of narcotic medication given to Resident #53 that was signed out on the narcotic sheet, 47 of these doses were not documented on the eMAR. The DON confirmed the eMAR should provide accurate information of the medications the resident had taken for appropriate treatment and management of the resident's care, and the inaccurate documentation on this resident's eMAR did not meet that standard. She stated the eMAR revealed the resident often went days without pain medications, when in reality, he received it two times a day. The DON confirmed the facility failed to accurately document the administration of the resident's pain medication into the eMAR system and that could lead to medication errors and inaccurate treatment plans. (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Physician Orders revealed orders dated 4/24/24 for Hydrocodone 5 mg (milligrams) - Acetaminophen 325 mg tablet: Give one tablet orally every 8 hours as needed and Acetaminophen 325 mg tablet: Give 2 tablets orally (650 mg total dose) every 6 hours as needed. Record review of Resident #53's Face Sheet revealed he was admitted to the facility on [DATE] with diagnoses including Pain. Record review of Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 4/30/24, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact.