

MSDH - Health Facilities Licensure and Certification

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>59LM</b>                  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>11/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>LANDMARK NURSING AND REHAB CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>100 LAUREN DRIVE<br/>BOONEVILLE, MS 38829</b> |                                                                                                                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                           |
| M 000                                                                        | <p>Initial Comments</p> <p>The State Agency (SA) conducted a Complaint Investigation (CI) MS00022990 at the facility on 11/02/23. During the survey, the SA determined the facility was in compliance with the Minimum Standards of Operation for Institutions of Aged or Infirm, state licensure requirements and there were no deficiencies cited. This SA investigated Facility Staffing related to new staff orientation and Medication Labeling.</p> <p>The facility held a license for 80 beds at the time of the survey, and the facility census was 63.</p> | M 000                                                                                     |                                                                                                                          |                                                                    |

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

11/13/23