STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255281	A. BUILDING _____ B. WING _____	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK OF DESOTO	3068 NAIL ROAD WEST HORN LAKE, MS 38637

(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 The State Agency (SA) conducted an annual recertification survey at the facility from 10/28/24 through 10/30/24. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F550, F578, F656, F686, F690, F755, F761 and F851. The facility held a license for 60 beds, with a census of 53.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) 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 must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights.	F 550		11/18/24

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

Electronically Signed | 11/14/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255281	A. BUILDING _____ B. WING _____	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK OF DESOTO	3068 NAIL ROAD WEST HORN LAKE, MS 38637

(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 550	Continued From page 1 The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review, the facility failed to provide privacy for one (1) of 20 residents reviewed as evidenced by a resident who was left uncovered and visible from the hallway. Resident # 17 Findings Include: A review of the facility's "Dignity and Respect" policy, revised on 7/22, stated: "A facility must treat each resident with dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of their quality of life, recognizing each resident's individuality. The facility shall protect and promote the rights of the resident... Residents will be examined and treated in a manner that maintains bodily privacy..." An observation from the hallway on 10/28/24 at 9:30 AM, revealed Resident #17's door was open and was lying in bed uncovered, with an adult	F 550	1. On 10/28/2024 the Licensed Practical Nurse covered resident #17 with his covers and then pulled the privacy curtain, to ensure his dignity was maintained. 2. All 53 Residents have the potential to be affected by this deficient Practice regarding Resident Rights/ Exercise Right. 3. An In-Service on the facility policy and procedure for "Dignity" was completed by the Director of Nurses on 10/28/2024. The Director of Nurses visually checked all residents in the building to ensure all residents dignity was being maintained on 10/28/24. Upon hire staff will be educated on resident right's then annually and as needed. 4. The Director of Nurses will visualize residents starting 10/31/2024 five (5)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255281	A. BUILDING _____ B. WING _____	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK OF DESOTO	3068 NAIL ROAD WEST HORN LAKE, MS 38637

(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 550	Continued From page 2 incontinence brief on the resident, stomach exposed, with the Percutaneous Endoscopic Gastrostomy (PEG) tube visible. In a follow-up observation from the hallway on 10/28/24 at 9:55 AM, Resident #17 was still lying uncovered in bed, with an adult brief, stomach, and PEG tube exposed, and with the door open and privacy curtain pulled back. An observation and interview on 10/28/24 at 10:20 AM, with Licensed Practical Nurse (LPN) #1 confirmed that Resident #17's door and privacy curtain were open and that the resident was in bed uncovered, with their hospital gown partially up, revealing an adult brief. The LPN stated that the resident never stays covered but acknowledged that staff should be keeping the privacy curtain pulled so that the resident was not visible from the hallway. In an interview on 10/29/24 at 9:00 AM, the Director of Nursing (DON) confirmed that Resident #17 being uncovered, with the brief and PEG tube visible from the hallway, was a dignity concern. Record review of the Admission Record revealed the facility admitted Resident #17 on 7/27/22 with a diagnosis of Cerebral Infarction.	F 550	times a week for four (4)weeks then one (1) time a week for two (2) weeks then monthly for two (2) months will continue longer if problems are identified. The Director of Nurses Will present findings in the Quarterly Improvement meeting. Quality Assurance Committee Meeting was conducted on 10/30/2024 a follow-up Quality Assurance Committee Meeting will be conducted again on 11/17/2024, and quarterly thereafter after the follow-up. Administrator will report any recurring problems to the monthly Quality Assurance Committee. Administrator will take necessary corrective action such as: Individual in-service/ and or disciplinary action could lead to termination.	
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.	F 578		11/18/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255281	A. BUILDING _____ B. WING _____	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK OF DESOTO	3068 NAIL ROAD WEST HORN LAKE, MS 38637

(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 578	Continued From page 3 §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, record review, and facility policy review, the facility failed to honor a resident's right to make health care	F 578	1. On 10/29/2024, Resident #58 was provided with her right to make decision related to her medical treatments.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255281	A. BUILDING _____ B. WING _____	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK OF DESOTO	3068 NAIL ROAD WEST HORN LAKE, MS 38637

(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 578	Continued From page 4 decisions related to cardiopulmonary resuscitation (CPR) for one (1) of 20 sampled residents. Resident #58 Findings Include: Review of the facility policy titled "Advance Directives" with a revision date of 7/15 revealed under, "Policy: The facility recognizes that all adults have a fundamental right to make decisions relating to their own medical treatment, including the right to accept or refuse medical care." Also revealed under, "Procedure:... The resident will be encouraged to participate in all aspects of decision-making regarding care and treatment. Statements by a competent resident regarding his/her desire to accept or refuse treatment will be documented in the resident's clinical record." Record review of the "Advanced Directive Consent" for Resident #58 revealed, the consent was initialed and signed by a family member dated 9/12/24 and that Resident #58 did not sign the consent. An interview with Resident #58 on 10/29/24 at 8:10 AM, revealed the facility had not gone over the advanced directives consent or code status with her. She revealed she would like to make her own healthcare decisions because she was still able. She confirmed she did not have a medical Power of Attorney (POA) established and explained she wanted everything done to save her life, should something happen. An interview with the Admission Coordinator on 10/29/24 at 8:24 AM, confirmed she did not go over the advanced directives and code status	F 578	Admissions Director revised and completed Advance Directive with Resident # 58. 2. All 53 Residents have the potential to be affected by this deficient Practice regarding Request/Refuse/Advance Directive. 3. Administrator in-Serviced Admission coordinator on 10/30/2024 regarding facility policy and procedures on Advance Directives. The Admission Coordinator initiated a facility audit on 10/31/2024, on all residents to ensure residents exercises their right to healthcare decisions. On all admissions and care plan reviews the Admission coordinator will ensure the resident rights to healthcare decisions. 4. The Administrator will monitor all new admission two time (2x) a week for four (4) weeks, then monthly for three (3) months to ensure residents exercise their right to Advance Directive. A Quality Assurance Committee Meeting was conducted on 10/30/2024, A follow-up Quality Assurance Committee Meeting will be conducted again on 11/17/2024, and quarterly thereafter after the follow-up. Administrator will report any recurring problems to the monthly Quality Assurance Committee. Administrator will take necessary corrective action such as: Individual in-service/ and or disciplinary action could lead to termination.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255281	A. BUILDING _____ B. WING _____	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK OF DESOTO	3068 NAIL ROAD WEST HORN LAKE, MS 38637

(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 578	Continued From page 5 with Resident #58 on admission. She explained that she allowed a family member to sign the consent because the family member was the Resident Representative (RR). The Admission Coordinator confirmed she should have spoken with the resident regarding her wishes. She revealed Resident #58 was cognitive and able to make her own healthcare decisions, and she did not have a medical POA to make decisions for her. An interview with the Administrator on 10/29/24 at 8:56 AM, confirmed Resident #58 was cognitive and should have been allowed to sign her consent related to code status on admission. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/10/24 revealed under, section C, a Brief Interview for Mental Status (BIMS) summary score of 12, which indicated Resident #58 was moderately cognitively impaired. Record review of the "Admission Record" revealed the facility admitted Resident #58 on 9/12/24.	F 578		
F 656 SS=G	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive	F 656		11/18/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255281	A. BUILDING _____ B. WING _____	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK OF DESOTO	3068 NAIL ROAD WEST HORN LAKE, MS 38637

(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 656	Continued From page 6 assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, record review, and facility policy review, the facility failed	F 656	Facility failed to develop a Comprehensive care plan for resident with	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255281	A. BUILDING _____ B. WING _____	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK OF DESOTO	3068 NAIL ROAD WEST HORN LAKE, MS 38637

(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 656	Continued From page 7 to develop a comprehensive care plan for a resident with pressure ulcers for two (2) of 20 sampled residents. Resident # 28 and Resident # 209 Findings Include: Review of the facility policy titled "Care Plan Process" with a revision date of 8/17 revealed, "...The Care Plan must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being..." Resident #28 A review of the "Skin & Wound Evaluation" dated 9/19/24 revealed that Resident #28 acquired an unstageable pressure ulcer on the right fourth (4th) ring finger on 9/19/24. The quarterly Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 9/16/24 indicated that Resident #28 had a functional limitation in the range of motion (ROM) in the upper extremity on one side. A review of the comprehensive care plan for Resident #28 showed that no pressure reduction interventions were in place to reduce the risk of pressure ulcers associated with the resident's right fourth finger. On 10/29/24 at 8:30 AM, during an interview with the Wound Treatment Nurse she explained that Resident #28 had developed a pressure ulcer on the right fourth ring finger due to pressure from fingers contracted in a fist. She acknowledged	F 656	pressure ulcers for (2) of 20 residents reviewed. (Resident #28 and Resident # 209) 1. On 10/28/2024, Assessment Nurse completed a wound care plan for Resident # 209 Assessment Nurse completed a care plan for Resident # 28 on Stage 3 pressure ulcer. One on One Education was provided to the Treatment Nurse, Nurse Case Manager, and Assessment Nurse by the Director of Nursing on 10/30/2024 on Comprehensive Care Plans process. 2. All 53 Residents have the potential to be affected by the deficient practice of Development/ Implement Comprehensive Care Plan. 3. The Director of Nurses initiated an in-service on 10/31/2024, for all licensed nursing staff on policy titled "Care Plan Process" to ensure that all residents are care plan appropriately. Director of Nursing and Assessment Nurse completed an audit on 11/01/2024 to ensure all residents care plans are up to date and appropriate for treatments. 4. The Director of Nursing , Nurse Case Manager, and Assessment Nurse will review the facility skin reports and Physician orders starting 10/31/2024, weekly for four (4) weeks then monthly for three months then quarterly. Director of Nursing will report findings to Quality Assurance meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255281	A. BUILDING _____ B. WING _____	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK OF DESOTO	3068 NAIL ROAD WEST HORN LAKE, MS 38637

(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 656	Continued From page 8 that pressure relief measures should have been implemented to prevent pressure ulcers on Resident #28's fingers. During an interview with MDS Nurse #1 and MDS Nurse #2 on 10/29/24 at 8:45 AM, they stated that the purpose of the care plan is to inform staff of the resident's required care. They confirmed that there was no care plan in place to prevent skin breakdown related to the right-hand contracture and agreed that such a plan should have been established. Record review of the "Admission Record" revealed the facility admitted Resident # 28 on 5/31/21 with a diagnosis of Cerebral Infarction. Resident #209 On 10/29/24 at 11:20 AM, an interview with the Wound Treatment Nurse revealed, Resident #209 had a new pressure wound on the right Achillies area. Record review revealed a care plan was not developed for Resident #209's wound care or pressure ulcer on the right Achilles. On 10/29/24 at 3:50 PM, an interview with the Administrator (ADM) confirmed Resident #209's wound care plan was not developed. An interview with the MDS Nurse #1 on 10/30/24 at 10:40 AM revealed the purpose of care plan development was so that anyone who looks at the wound knew the level of care needed. Record review of the "Admission Record" revealed the facility admitted Resident #209 on	F 656	A Quality Assurance Committee Meeting was conducted on 10/30/2024, A follow-up Quality Assurance Committee Meeting will be conducted again on 11/17/2024, and quarterly thereafter after the follow-up. Administrator will report any recurring problems to the monthly Quality Assurance Committee. Administrator will take necessary corrective action such as: Individual in-service/ and or disciplinary action could lead to termination.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255281	A. BUILDING _____ B. WING _____	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK OF DESOTO	3068 NAIL ROAD WEST HORN LAKE, MS 38637

(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 656	Continued From page 9 10/9/24 with a medical diagnosis of Displaced Fracture of the Lower Epiphysis of Right Femur.	F 656		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interview the facility failed to provide treatment and services to prevent pressure ulcers for two (2) of five (5) residents observed with pressure ulcers. Resident #28 and Resident # 209 Findings Included: Record review of facility policy Pressure Ulcer Prevention and Treatment Intervention Guidelines, revised 10/22, revealed "C. Protection from Fiction or Shear...4. Provide padding for casts, braces, splints, oxygen tubing, shoes etc. as needed to prevent friction. 5. Remove orthotics on a regular basis for skin inspection...Therapy Department Interventions...3. Explore possible	F 686	Facility failed to provide treatment and services to prevent pressure ulcers for (2) of 5 Residents observed with pressure ulcers. (Resident # 28 and Resident # 209). 1 . On 10/29/2024 Physician orders were clarified for resident #209 regarding brace Resident # 28 were revised. One on One education completed with Treatment Nurse by the Director of Nursing on 10/30/2024 on obtaining physicians orders as needed and pressure ulcer staging. Resident # 28 and Resident # 209 was assessed for any adverse effects of failing to provide treatment and services to prevent pressure ulcers on 10/29/2024 by	11/18/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255281	A. BUILDING _____ B. WING _____	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK OF DESOTO	3068 NAIL ROAD WEST HORN LAKE, MS 38637

(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 686	Continued From page 10 therapy interventions for...c. Splinting/orthotic modifications... 1. Provide pressure ulcer topical treatments as ordered" Resident #28 A review of the "Skin & Wound Evaluation" dated 9/19/24, revealed that Resident #28 acquired an unstageable pressure ulcer on the right fourth (4th) ring finger on 9/19/24. Record review revealed measurements of 1.4 centimeters (cm) area, 1.4 cm length, 1.3 cm width and depth not applicable (n/a). The quarterly Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 9/16/24 Section GG revealed revealed Resident #28 had a functional limitation in the range of motion in the upper extremity on one side. A record review of Order Listing Report for September and October 2024 revealed no orders for pressure relief devices for Resident # 28. During an observation and interview with Licensed Practical Nurse (LPN) #2 on 10/29/24 at 8:00 AM, Resident #28 was observed with a palm shield in place on the right hand. LPN #2 confirmed that Resident #28 had a contracture in the right hand and stated that the palm shield was applied only after the pressure ulcer developed on the right 4th ring finger. She verified that no splinting or other pressure relief interventions were in place before the pressure ulcer developed. In an interview with the Wound Treatment Nurse on 10/29/24 at 8:30 AM, she explained that	F 686	the Director of Nursing with negative findings noted. An 100% audit was completed on 10/31/2024 on all residents with assisted devices to ensue no other negative findings. 2. All 53 Residents have the potential to be affected by the deficient practice regarding Treatment/Service to prevent/Heal Pressure Ulcer. 3. The Director of Nurses initiated an in-service on 10/31/2024 with all licensed nursing staff on policy titled "Pressure Ulcer Prevention and Treatment Interventions Guidelines". The Director of Nurses and Treatment Nurse completed assessment audit on 10/31/24 on all residents with wounds to ensure proper staging and appropriate orders for treatment. 4. The Director of Nursing and Treatment Nurse will monitor residents starting 10/31/2024 at risk for skin breakdown, and residents with assistive devices by making rounds five (5) times a week for four (4) weeks then monthly for three (3) months then quarterly. Therapy to screen residents quarterly and as needed. The Director of Nursing will report findings to Quality Assurance meeting. A Quality Assurance Committee Meeting was conducted on 10/30/2024. A follow-up Quality Assurance Committee Meeting will be conducted again on 11/17/2024, and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255281	A. BUILDING _____ B. WING _____	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK OF DESOTO	3068 NAIL ROAD WEST HORN LAKE, MS 38637

(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 686	Continued From page 11 Resident #28 had developed a pressure ulcer on the right fourth ring finger due to pressure from the fingers being contracted in a fist. She stated that when she identified the pressure ulcer, she contacted therapy to request a pressure relief device. She acknowledged that pressure relief measures should have been in place to prevent pressure ulcers on Resident #28's fingers. She confirmed that there were no orders or documentation for the use of the palm shield. In an interview with the Rehabilitation Director on 10/30/24 at 9:00 AM, she verified that Resident #28 did not have a palm shield before developing the pressure ulcer on the right 4th finger and confirmed that she was consulted, and the shield was implemented after the ulcer appeared. Record review of the "Admission Record" revealed the facility admitted Resident # 28 on 5/31/21 with a diagnosis of Cerebral Infarction. Resident #209 An observation and interview with Resident #209 on 10/29/24 at 10:16 AM revealed, she was lying in bed with an immobilizer to the right leg. The resident verbalized she had an unrepaired femur fracture and revealed she had a new sore that developed under the brace since she admitted. She explained that she followed up with her orthopedic doctor last week, and he asked her to use foam under the brace, but the facility did not have any foam. An interview with the Wound Treatment Nurse on 10/29/24 at 11:20 AM revealed Resident #209 had a new pressure wound caused by the immobilizer on the Achilles area. She explained that she was notified by the Therapy Rehab	F 686	quarterly thereafter after the follow-up. Administrator will report any recurring problems to the monthly Quality Assurance Committee. Administrator will take necessary corrective action such as: Individual in-service/ and or disciplinary action could lead to termination.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255281	A. BUILDING _____ B. WING _____	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK OF DESOTO	3068 NAIL ROAD WEST HORN LAKE, MS 38637

(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 686	Continued From page 12	F 686		

Director on 10/21/24 that the residents' immobilizer was sliding down and had caused a sore. She revealed she had been treating the wound since she was made aware, but the treatment order was not added to the Treatment Administration Record (TAR) until 10/26/24, and she had not staged the wound. The Wound Nurse confirmed Resident #209's skin had not been assessed under the immobilizer every day to determine if the resident had any skin breakdown.

Record review of the "Wound Evaluation" dated 10/22/24 revealed the wound to the right Achilles was not staged and measured 0.94 cm in length and 0.56 cm in width, with no determination on depth.

Review of the October 2024 "Treatment Administration Record" for Resident #209 revealed an order, dated 10/26/24, "Clean open area to right heel with NS (normal saline) and pat dry, apply Xeroform and cover with bandage every other day until resolved" with a discontinue date of 10/29/24. Also revealed an order, dated 10/29/24, "Clean open area to right Achilles with NS (normal saline) and pat dry, apply TAO (triple antibiotic ointment) and cover with bandage every other day until resolved."

Record review of the "Order Listing Report" revealed there was not a physician order for Resident #209's leg immobilizer or to monitor the skin under the brace for skin breakdown.

An interview with the Director of Nursing (DON) on 10/29/24 at 12:50 PM confirmed, Resident #209 did not have an order for the right leg immobilizer. She revealed it was not clear to her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255281	A. BUILDING _____ B. WING _____	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK OF DESOTO	3068 NAIL ROAD WEST HORN LAKE, MS 38637

(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 686	Continued From page 13	F 686		

why the staff would not have called and followed up on how the resident was supposed to wear it.

Record review of the "Physician Consultation Report" dated 10/24/24 revealed under, "Findings: ... Pressure sores where hinges are present." Also revealed under, "Recommendations: When pt is in bed open brace completely to relieve pressure; Apply thin layer of foam to posterior calf and thigh portion of brace."

An interview with the Wound Treatment Nurse on 10/29/24 at 2:30 PM confirmed she did not implement the orders recommended by the Orthopedic Physician. She revealed the foam would have been too thick under the brace and stated, "I don't think foam would work." She revealed Resident #209 had told her the hospital applied foam under the immobilizer, and it was too tight.

An interview with the Administrator (ADM) on 10/29/24 at 2:48 PM, confirmed the skin should be assessed underneath an immobilizer daily to ensure there was no skin breakdown caused by the device. She confirmed Resident #209's wound was avoidable, if the skin under the immobilizer had been assessed. She revealed the physician's recommendations should have been followed.

An interview with the Therapy Rehab Director on 10/30/24 at 9:10 AM revealed she usually had to take Resident #209's immobilizer off to reposition it correctly. She revealed she observed the area to the resident's leg and reported it to the nurse on duty on 10/20/24. She stated the nurse thought the brace had rubbed the area on the leg,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255281	A. BUILDING _____ B. WING _____	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK OF DESOTO	3068 NAIL ROAD WEST HORN LAKE, MS 38637

(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 686	Continued From page 14 and she needed something to pad the area for support. The therapist revealed they placed a towel under the brace that day for extra protection, and she told the Wound Treatment Nurse the following day. An interview with the Wound Treatment Nurse on 10/30/24 at 10:25 AM confirmed Resident #209's wound was avoidable if the proper monitoring under the brace had been done. Record review of the "Admission Record" revealed the facility admitted Resident #209 on 10/9/24 with a medical diagnosis of Displaced Fracture of the Lower Epiphysis of Right Femur. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/16/24 revealed under, section C, a Brief Interview for Mental Status (BIMS) summary score of 15, which indicated Resident #209 was cognitively intact.	F 686		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an	F 690		11/18/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255281	A. BUILDING _____ B. WING _____	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK OF DESOTO	3068 NAIL ROAD WEST HORN LAKE, MS 38637

(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 690	Continued From page 15 indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to provide appropriate care services for (1) one of (5) resident care observations. (Resident # 57) Findings include: A review of the facility policy titled, "Perineal Care," latest revision date 01/24 revealed. ...Resident with Catheter:.. 4.) Using a clean washcloth or wash wipe, start at the meatus and wash the tubing in a circular motion away from the body... Rinse using the same method..." An observation of catheter care with Certified Nurse Assistants (CNA) #1 and CNA #2 for	F 690	Facility failed to provide appropriate care services for (1) one of (5)residents Director of Nursing assessed resident #57 for any adverse effects no negative finding. 1. On 10/29/2024 all Certified Nursing Assistants were initiated an in-service to watch a required training video titled "Perineal care". 2. All 53 Residents have the potential to be affected by the deficient practice regarding Bowel and Bladder 3. A second in-service was initiated on the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255281	A. BUILDING _____ B. WING _____	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK OF DESOTO	3068 NAIL ROAD WEST HORN LAKE, MS 38637

(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 690	Continued From page 16 Resident #57 on 10/29/24 at 11:34 AM, revealed CNA #1 cleaned one side of the urinary catheter from the urinary meatus downward with a clean soapy wet washcloth, and then cleaned the other side with a clean area section of the washcloth. CNA #1 then placed the dirty washcloth into the clean water in the wash basin, rinsed it out and used the same dirty washcloth to rinse the urinary catheter tubing/urinary meatus all in the same swipe wearing the same gloves worn during cleaning process.. In an interview with CNA #2 on 10/29/24 at 11:56 AM, she revealed that she was in the room only to help CNA #1 if she needed any help. She confirmed that CNA #1 contaminated the clean water in the basin when she put the dirty washcloth in it. She then stated CNA #1 should also have used a clean washcloth to rinse the resident. In an interview with CNA #1 on 10/29/24 at 11:59 AM, she revealed she did not even realize she forgot to change her gloves as well as she used the same dirty washcloth to rinse Resident #57's meatus and catheter tubing. She stated that it was cross contamination and could lead to infections. In an interview with the Infection Control/Treatment Nurse on 10/29/24 at 12:12 PM, she revealed that the CNA should have performed hand hygiene and used a clean washcloth to rinse the perineal area after cleansing the resident to prevent cross contamination of bacteria. She stated that failing to do this could lead to urinary tract infections for the resident.	F 690	facility policy and procedure for "Perineal Care " completed by Director of Nursing on 10/30/2024. Director of Nursing initiated return demonstration on perineal care for all certified Nursing Assistants on perineal care starting 10/30/2024. Upon hire certified Nursing Assistants will be provided with a training and competency regarding perineal care annually and as needed. 4. The Director of Nursing will monitor five residents a week for perineal care starting 10/30/2024 for four (4) weeks then monthly for three (3) months then quarterly. The Director of Nursing will present findings to the Quarterly Quality Meeting. A Quality Assurance Committee Meeting was conducted on 10/30/2024. A follow-up Quality Assurance Committee Meeting will be conducted again on 11/17/2024, and quarterly thereafter after the follow-up. Administrator will report any recurring problems to the monthly Quality Assurance Committee. Administrator will take necessary corrective action such as: Individual in-service/ and or disciplinary action could lead to termination.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255281	A. BUILDING _____ B. WING _____	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK OF DESOTO	3068 NAIL ROAD WEST HORN LAKE, MS 38637

(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 690	Continued From page 17 Record review of the "Admission Record" revealed the facility admitted Resident # 57 on 9/16/24 with diagnoses including Neuromuscular dysfunction of the bladder. Record review of Resident #57's Section C of the Minimum Data Set (MDS) dated 9/23/24 revealed on a Brief Interview for Mental Status (BIMS) score was 15, indicating the resident was cognitively intact. In Section H Bladder and Bowel item H0100 revealed the resident had an indwelling urinary catheter.	F 690		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.	F 755		11/18/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255281	A. BUILDING _____ B. WING _____	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK OF DESOTO	3068 NAIL ROAD WEST HORN LAKE, MS 38637

(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 755	Continued From page 18 §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to maintain a system of medication records that enables periodic accurate reconciliation and accounting for all controlled medications for (1) one of (3) three narcotic storage areas reviewed. Findings include: A review of the facility policy titled, "Drug-Controlled Substances," latest revision 11/17 revealed, "Regulations require that the facility have a system in place to account for the receipt, usage, disposition, and reconciliation of all controlled medications ... A controlled drug count is to be done at the beginning of each shift by the outgoing and on-coming nurses..." An observation of the narcotic box in the medication room refrigerator with Licensed Practical Nurse (LPN) # 1 on 10/29/24 at 8:30 AM, revealed four (4) vials of Emergency Drug Kit (EDK) Lorazepam two (2) mg/ml (milligram/milliliter). LPN #1 revealed she and the other medication nurse on duty have access to the narcotic box in the refrigerator. She then confirmed the Lorazepam was not counted every shift with the other narcotics on the medication carts with the ongoing and off going shifts. LPN	F 755	Facility failed to maintain a system of medication records that enables periodic accurate reconciliation and accounting for all controlled medications for (1) of (3) narcotic storage areas reviewed. 1. On 10/29/2024 Licensed Practical Nurse and Pharmacy Consultant open locked box in refrigerator checked the Emergency Drug Kit for accuracy. Narcotic log implemented for Emergency Drug Kit for Nurses to count every shift. 2. All 53 Residents have the potential to be affected by this deficient practice regarding Pharmacy Services Procedures/Pharmacist Records. 3. An in-service was initiated on 10/30/2024 for all Licensed Nursing staff on policy titled " Medication Storage" for nurses to count Emergency Drug Kit daily to ensure medication is present by Director of Nursing. Upon hire all licensed staff will be educated on medication storage and as needed. 4. The Director of Nursing will monitor weekly Emergency Drug Kit count starting	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255281	A. BUILDING _____ B. WING _____	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK OF DESOTO	3068 NAIL ROAD WEST HORN LAKE, MS 38637

(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 755	Continued From page 19 #1 also revealed she was unaware how long the Lorazepam vials had been in the refrigerator. In an interview with the Pharmacy Consultant on 10/29/24 at 8:35 AM, he confirmed that the medication nurses should be reconciling the EDK Lorazepam in the medication room narcotic box every shift. He then revealed that a potential concern from not reconciling narcotics is potential narcotic diversion. In an interview with LPN #2 on 10/29/24 at 10:10 AM, she stated she has a key to the narcotic lock box in the medication room refrigerator and was aware there was Lorazepam in the narcotic box. She then confirmed that the Lorazepam was not reconciled every shift with the other narcotics on the medication cart and is not listed in her narcotic count book. She stated a concern from not counting the narcotic every shift was it could have been missing, and we would not know when it went missing. A review of an Emergency Box Requisition form with the Pharmacy Consultant on 10/29/24 at 10:20 AM, revealed the four vials of Lorazepam in the medication room lock box were delivered on 5/04/23. He revealed after further observation of the Lorazepam, the EDK requisition form to be counted each shift was still in the refrigerator with the box of Lorazepam vials. The pharmacy Consultant then confirmed the Lorazepam was never added to either medication cart-controlled record books for the nurses to reconcile every shift. In an interview with the Director of Nursing (DON) on 10/29/24 at 10:30 AM, she confirmed the EDK Lorazepam should have been added to the	F 755	10/30/2024 one (1) time a week for four (4) weeks and monthly for three (3) months Director of Nurses will present finding to Quality Assurance. A Quality Assurance Committee Meeting was conducted on 10/30/2024. A follow-up Quality Assurance Committee Meeting will be conducted again on 11/17/2024, and quarterly thereafter after the follow-up. Administrator will report any recurring problems to the monthly Quality Assurance Committee. Administrator will take necessary corrective action such as: Individual in-service/ and or disciplinary action could lead to termination.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255281	A. BUILDING _____ B. WING _____	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK OF DESOTO	3068 NAIL ROAD WEST HORN LAKE, MS 38637

(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 755	Continued From page 20 narcotic count book to be counted each shift.	F 755		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and facility policy review, the facility failed to ensure a resident's environment was free from accident hazards, as evidenced by, medications left at bedside for one (1) of twenty sampled residents. Resident #58	F 761	Facility failed to ensure a Resident's environment was free from accident hazards as evidenced by medication left at bedside for one (1) of 20 Resident reviews. 1. On 10/28/2024 Resident #58 bedside	11/18/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255281	A. BUILDING _____ B. WING _____	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK OF DESOTO	3068 NAIL ROAD WEST HORN LAKE, MS 38637

(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 761	Continued From page 21 Findings Include: Review of the facility policy titled "Medication Storage" with a revision date of 11/17 revealed under, "There shall be storage areas provided that assure adequate space, equipment and security for medications within the facility..." An observation and interview on 10/28/24 at 9:50 AM, revealed Resident #58 lying in bed and on the bedside table was a six (6) ounce bottle of red spray liquid with a label that read, "Sore Throat Spray" and a one (1) fluid ounce white bottle that read, "Lubricating Eye Drops". The resident revealed that she used the eye drops about six times a day for dry eyes and administered it herself. She revealed that she used the sore throat spray as needed for a sore throat. She explained the staff knew she had it because it had been on the table since she was admitted to the facility. An interview with Licensed Practical Nurse (LPN) #1 on 10/28/24 at 10:30 AM, confirmed Resident #58 had medications at her bedside. She revealed the resident did not have a physician order for the medication and the resident could be using the medication too often without staff monitoring, or a confused resident could come along and take it. An interview with the Administrator (ADM) on 10/29/24 at 8:58 AM, revealed the residents were not supposed to have medications at bedside. She confirmed Resident #58 could take too much, or she could have a reaction to the medications, and that all medications should be secured and put away.	F 761	medication was removed and resident was assessed for self-administration of medications by Registered Nurse. Resident performed a return demonstration by placing eye drop in eyes. Resident was assessed by Registered Nurse for any adverse effects no negative findings. Physician order was obtained on 10/28/2024 for self administration of medication education was provided to resident for usage and reporting. Medication will be available upon resident request at medication cart. 2. All 53 Residents have the potential to be affected by deficient practice regarding Storage of Drugs and Biologicals. 3. An in-service was initiated on 10/30/2024 with all nursing staff by Director of Nursing on medication storage and reporting any finding of medications in resident rooms. Director of Nurses and Treatment Nurse completed a visual audit on 10/30/2024 in all resident rooms to ensure no bedside medication. 4. The Director of Nursing and Administrator will monitor all residents rooms for medications at bedside starting 11/01/2024 five(5) times a week for four (4) weeks and then monthly for three (3) months and then quarterly. The Director of Nurses and Administrator will report findings to the Quality Assurance meeting. A Quality Assurance Committee Meeting	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255281	A. BUILDING _____ B. WING _____	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK OF DESOTO	3068 NAIL ROAD WEST HORN LAKE, MS 38637

(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 761	Continued From page 22 Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/10/24 revealed under Section C, a Brief Interview for Mental Status (BIMS) summary score of 12, which indicated Resident #58 was moderately cognitively impaired. Record review of the "Admission Record" revealed the facility admitted Resident #58 on 10/4/24 with a medical diagnosis of Cellulitis of the left lower leg.	F 761	was conducted on 10/30/2024. A follow-up Quality Assurance Committee Meeting will be conducted again on 11/17/2024, and quarterly thereafter after the follow-up. Administrator will report any recurring problems to the monthly Quality Assurance Committee. Administrator will take necessary corrective action such as: Individual in-service/ and or disciplinary action could lead to termination.	
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(p)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(p)(2) Submission requirements. The facility must electronically submit to CMS	F 851		11/18/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255281	A. BUILDING _____ B. WING _____	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK OF DESOTO	3068 NAIL ROAD WEST HORN LAKE, MS 38637

(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 851	Continued From page 23 complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(p)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(p)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(p)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to submit accurate direct care staffing information to the Centers for Medicare and Medicaid Services (CMS) as required for the	F 851	Facility failed to submit accurate staffing information into the payroll-Based Journal system for (1) of (4) quarters reviewed. Third (3) Quarter 2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255281	A. BUILDING _____ B. WING _____	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK OF DESOTO	3068 NAIL ROAD WEST HORN LAKE, MS 38637

(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 851	Continued From page 24 third quarter (Q3) of fiscal year (FY) 2024 (April 1-June 30). Findings include: Record review of a letter, on facility letter head, signed by the Administrator, revealed that the facility does not have a policy related to Payroll Based Journal (PBJ) submission. A record review of the facility's PBJ Staffing Data Report for Q3 FY 2024 revealed that the facility triggered for excessively low weekend staffing. In an interview on 10/29/24 at 12:45 PM, the Administrator stated that the facility had not submitted accurate PBJ staffing data to CMS for the third quarter of FY 2024. She explained that the corporate office was responsible for submitting PBJ staffing data for the facility; she provided the agency/contract staffing hours, while the corporate office pulls hours for facility staff from payroll records. She noted that administrative staff were sometimes reassigned to provide direct resident care when there are call-ins, but there was currently no way to report this as direct care, which contributed to the PBJ reporting error.	F 851	1. The facility was unable to make data entry changes corrections for the third quarter of the fiscal year 2024, because of the data entry date in payroll -Based journal. 2. All 53 Residents in the facility has the potential to be affected by the deficient practice regarding Payroll Based Journal. 3. The Administrator in-serviced the Director of Nurses on 10/31/2024 to communicate any changes for additions with the agency staff and/or Administrative staff working in direct care to Administrative Assistant so she can make sure the data is accurate. 4. The Administrator will audit employee and agency staff timesheets against Payroll-Based Journal entries for accuracy starting 10/31/2024, four (4) times a week for two (2) weeks, three (3) times a week for 2 weeks, and 2 times a week for 2 weeks to ensure time is entered accurately results of these audits will be reviewed by the facility quality assurance committee. A Quality Assurance Committee Meeting was conducted on 10/30/2024, A follow-up Quality Assurance Committee Meeting will be conducted again on 11/17/2024, and quarterly thereafter after the follow-up. Administrator will report any recurring problems to the monthly Quality Assurance Committee. Administrator will take necessary corrective action such as:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255281	A. BUILDING _____ B. WING _____	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK OF DESOTO	3068 NAIL ROAD WEST HORN LAKE, MS 38637

(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 851	Continued From page 25	F 851	Individual in-service/ and or disciplinary action could lead to termination.	