

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>R-C<br/>04/14/2025</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>On 4/14/25, the State Agency (SA) conducted an onsite revisit related to the complaint investigation that was completed on 3/18/25. The information reviewed confirmed the facility had put measures in place to correct the deficient practice and sustain compliance with the Minimum Standards of Operation for Institutions for the Aged or Infirm. The SA is recommending that the facility be placed back in compliance effective 4/11/25.</p> <p>The census at the time of the revisit was 61 and the facility held a license for 80 beds.</p> | {M 000}                                                                                   |                                                                                                                          |                                                                |

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

04/18/25