Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/19/2026**

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

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M0000	Initial Comments The State Agency (SA) conducted an annual re-certification survey at facility from 3/17/26 through 3/19/26. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements and cited M500, M620, M625, M715 and M1570. The census at the time of the survey was 54 and the facility is licensed for 60 beds.	M0000		
M0500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be	M0500		

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

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M0500	Continued from page 1 limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the	M0500		

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M0500	Continued from page 2 emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and	M0500		

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M0500	Continued from page 3 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Pattern Based on record review, staff interview, and facility policy review, the facility failed to ensure residents' right to be free from chemical restraints for four (4) of five (5) residents reviewed for psychotropic drug usage. Resident #1, Resident #6, Resident #12, and Resident #38 Findings Include: Review of the facility policy "Gradual Dose Reduction (GDR) for Psychotropic Medications" with revision date of 11/17 revealed "A Gradual Dose Reduction (GDR) is a stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued. Within 1st (first) year after admission on psychotropic or after initiation: GDR in 2 (two) separate quarters, with at least one month between attempts. After 1st (first) year GDR annually...." Review of facility policy titled “Psychotropic Medications” with review date 2/2025, revealed, “…as needed (PRN) orders for psychotropic medications will be limited to 14 days unless the physician identifies the rationale to extend the medication beyond 14 days. PRN anti-psychotic drugs will be limited to 14 days and will not be renewed unless the physician evaluates the resident for appropriateness of the medication…The facility shall implement gradual dose reductions (GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication…” Resident #1 Record review of Resident #1’s “Order Summary Report” revealed an order dated 2/13/26, “Klonopin (anti-anxiety) 0.5 MG (milligram) oral tablet (Clonazepam) give 1 (one) tablet via PEG (percutaneous endoscopic gastrostomy) Tube every 8 (eight) hours as	M0500		

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M0500	Continued from page 4 needed for agitation and combativeness" without a stop date. An interview with the Pharmacy Consultant on 3/18/26 at 2:20 PM revealed he was aware that Resident #1 was ordered PRN (as needed) klonopin without a stop date and stated he had sent a notification to the provider the previous month. He confirmed the PRN order remained unaddressed. An interview with the Director of Nursing (DON) on 3/18/26 at 2:32 PM confirmed Resident #1's as needed Klonopin order should have had a stop date after 14 days and then be re-evaluated for continued need. Record review of the "Face Sheet" revealed the facility admitted Resident #1 on 1/28/26 with medical diagnoses including Encounter for Attention to Gastrostomy and Generalized Anxiety Disorder. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/4/26 revealed under section C, a Staff Assessment for Mental Status indicated Resident #1's cognitive skills for daily decision making was moderately impaired. Resident #6 Record review of Resident #6's March Medication Administration Record (MAR) revealed a physician order for Lorazepam Oral Concentrate 1 milligram (mg)/0.5 milliliter (mL), give 0.5 mL by mouth every two (2) hours as needed for anxiety, with a start date 8/13/2025; however, the order did not have a stop date. Record review of Resident #6's March MAR revealed a physician order for Lorazepam Oral Concentrate 2 milligram/milliliter, give 1 mL by mouth every two (2) hours as needed for anxiety, with a start date 8/13/2025; however, the order did not have a stop date. During an interview on 3/18/2026 at 2:20 PM, the DON confirmed the two (2) as needed (PRN) Lorazepam orders did not have a stop date. She stated the hospice nurse and the resident's family did not want the medication discontinued.	M0500		

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M0500	Continued from page 5 Review of a pharmacy recommendation related to Ativan 0.5 mg daily, dated 2/23/2026, revealed no evidence the physician reviewed the recommendation. Review of the Admission Record indicated Resident #6 was admitted to the facility on 10/4/2024 with a medical diagnosis that included senile degeneration of brain, dementia and bipolar disorder. A review of the MDS with an ARD of 2/25/26, revealed under section C that a BIMS was not conducted because the resident was rarely or never understood. Resident #12 During an interview on 03/19/26 at 9:07 AM with DON, she revealed that the facility's psychiatrist was the one responsible for completing the GDR's and addressing the recommendations. She revealed that their psychiatrist quit about three months ago and now the Medical Director was responsible. DON revealed that the medical director currently had the pharmacist recommendations in his folder, but none had been addressed nor returned to them. She confirmed that the purpose of the GDR's was to ensure residents' medications were maintained on the lowest effective dose possible. Record review of Resident #12's "Pharmaceutical Consultant Report" revealed that the last completed Psychoactive GDR was dated 02/11/25. Record review of Resident #12's "Consultant Pharmacist Recommendation" dated 12/29/25 revealed that notices were sent to the provider to consider dose reductions for Trazodone and Haldol and they were not addressed. Record review of Resident #12's "Order Summary Report" revealed an order dated 01/17/23 for Trazodone HCL (hydrochloride) 25mg (milligrams) for 1 tablet by mouth at bedtime and an order dated 11/04/25 for Haloperidol Decanoate IM (Intramuscular) Solution 50mg (milligrams)/ml (milliliter) to inject 50mg intramuscularly one time a day starting on the 14th every month and ending on the 14th every month related to Schizophrenia. Record review of Resident #12's "Face Sheet" revealed an admission date of 04/18/19 and that she had diagnoses that included Unspecified Dementia, Anxiety, and Schizophrenia.	M0500		

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M0500	Continued from page 6 Record review of Resident #12's MDS with ARD of 02/18/26 under Section C - Cognitive Patterns revealed a BIMS Score of 15 which indicated that she was cognitively intact. Resident #38 Record review of Resident #38's "Order Summary Report" revealed an order dated 7/15/24, "Duloxetine (antidepressant) 30 MG give 1 (one) tablet orally two times a day related to Major Depressive Disorder." Record review of the "Consultant Pharmacist Recommendation" dated 12/29/25 revealed a notice was sent to the provider to consider a dose reduction for duloxetine 30 mg which remained unaddressed. An interview with the DON on 3/18/26 at 2:32 PM revealed the facility's psychiatrist quit in December 2025 without notice, and at that time he was responsible for completing the GDR's and addressing the pharmacist recommendations. She revealed the medical director currently had the pharmacist recommendations in his folder; however, none had been signed or addressed. She confirmed the purpose of the GDR's was to ensure residents were maintained on the lowest effective dose and to prevent overmedication. Record review of the "Face Sheet" revealed the facility admitted Resident #38 on 8/29/22 with medical diagnoses that included major depressive disorder, recurrent. Record review of the MDS with an ARD of 12/29/25 revealed under section C, a BIMS summary score of 15, indicating Resident #38 was cognitively intact.	M0500		
M0620	45.21.4 Urinary incontinence Urinary incontinence. Residents with urinary incontinence shall be assessed for need of bladder retraining program. An indwelling catheter will not be used unless the resident ' s clinical condition indicates that catheterization is necessary. These residents shall receive treatment and services to prevent urinary tract infections. This LICENSURE REQUIREMENT is NOT MET as evidenced by:	M0620		

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M0620	Continued from page 7 Level II Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure proper positioning and management of an indwelling urinary catheter drainage system for one (1) of one (1) residents reviewed for urinary catheter. Resident #11 Findings Include: Review of the facility policy titled “Perineal Care,” revised 1/24, revealed under “Resident with Catheter: … 7. Ensure tubing is not positioned above the level of the bladder.” An observation conducted on 3/17/26 at 11:29 AM revealed Resident #11 lying in bed with a urinary catheter drainage bag attached to the lower portion of the bed frame. Record review of Resident #11’s “Order Summary Report” revealed an order dated 7/3/25, “Foley catheter care Q (every) shift and PRN (as needed).” During an observation of catheter care provided to Resident #11 by Certified Nurse Aide (CNA) #1 and Registered Nurse (RN) #1 on 3/18/26 at 11:00 AM, the urinary drainage bag was removed from the lower bed frame and placed in the bed with the resident during catheter care. This positioning resulted in urinary backflow from the drainage bag into the tubing. An interview with RN #1 on 3/18/26 at 11:12 AM confirmed the urinary drainage bag was not positioned appropriately to allow for proper drainage during catheter care and stated the urine could reflux and increase the risk for a urinary tract infection. Record review of the "Face Sheet" revealed the facility admitted Resident #11 on 7/2/25 with medical diagnoses including Diverticulosis of Intestine without Perforation and Pressure Ulcer of Sacral Region, Stage 3. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/13/26 revealed under Section C, a Brief Interview for Mental Status (BIMS) summary score of 15, indicating Resident #11 was cognitively intact.	M0620		
M0625	45.21.5 Range of motion	M0625		

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M0625	Continued from page 8 Range of motion. Residents with limited range of motion shall receive treatment and services to increase range of motion or prevent further decline in range of motion. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on observation, interview, record review, and facility policy review the facility failed to provide services to maintain or improve range of motion by not ensuring a physician ordered splint was applied daily for 1 (one) of 2 (two) residents reviewed. Resident #17. Findings Included: Record review of the facility policy "Range of Motion" with revision date of 01/24, revealed that the purpose was "To improve or maintain joint mobility and muscle strength" and "To prevent contractures...." Observations on 03/17/25 at 10:55 AM and on 03/18/26 at 8:15 AM revealed Resident #17 lying in bed, he was non-verbal with his eyes open. His right hand was contracted and there was no wrist splint device in place. It was observed that there was a hand splint on the seat of the wheelchair that was against the wall. An interview and observation on 03/18/26 at 1:50 PM with Registered Nurse (RN) #1, revealed that they only had one resident requiring hand splints in the facility. She revealed that Resident #17 had received therapy services in the past and they had put a hand splint on him but since he had been discharged from them, he did not wear one. An observation with RN #1 in Resident # 17's room confirmed that there was a hand splint in his wheelchair in the corner of the room and his name was written on it. She stated, "I don't know why that is in here, I've never put a hand splint on him." RN #1 confirmed that his right hand was contracted. She revealed that she wasn't aware there was an order for a splint to be put on, further stating that there wasn't anything on his MAR (Medication Administration Record) or TAR (Treatment Administration Record) to indicate that he needed to wear the splint every day. RN #1 revealed that not wearing a hand splint could cause the contracture to get worse. An interview on 03/18/26 at 2:15 PM with Director of Nursing, revealed that Resident #17 was supposed to wear a hand splint for four hours every day. DON viewed and confirmed the order for the hand splint to be placed for four hours a day and stated she didn't realize it wasn't getting done. She also reviewed Resident #17's TAR and confirmed the order was not put in correctly and it did not carry over for the nurses	M0625		

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M0625	Continued from page 9 to know to do it. DON revealed that by not applying the hand splint daily as ordered, it could result in worsening of the contracture. An interview on 03/18/26 at 2:30 PM with Director of Rehab revealed that they had worked with Resident #17 in the past on stretching exercises to see if he would be able to straighten out his hand. She revealed that back in the summer of 2025, they ordered him and other residents hand splints, and they started putting the splint on Resident #17 for four hours a day. She revealed that they also educated the nurses and the nurses were applying the splint, and it was their responsibility to ensure it was on. Director of Rehab revealed that failure to apply the hand splint daily as ordered could result in the contracture worsening. Record review of Resident #17's "Order Listing Report" revealed an order dated 05/26/25 to apply right wrist splint for 4 hours per day. 2-hour skin checks under splint/brace for redness irritation, swelling, breakdown and adequate circulation/sensation prn (as needed) while splint in place every day shift for contracture prevention. Record review of Resident #17's March 2026 TAR revealed no order to apply the wrist splint every day. Record review of Resident #17's "Face Sheet" revealed an admission date of 07/27/22 and that he had diagnoses that included Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Right Dominant Side and Contracture of Right Hand.	M0625		
M0715	45.24.4 Labeling of drugs Labeling of drugs. Each facility shall follow the Mississippi State Board of Pharmacy labeling requirements. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure insulins were properly stored in accordance with manufacturer's guidelines to maintain safety and effectiveness for one (1) of two (2) medication carts observed. 300 hall Findings Include: Review of the facility policy titled “Medication Storage,” revised 11/17, revealed, “Storage, supplies and equipment necessary for appropriate temperatures and conditions per the manufacturer’s specifications.”	M0715		

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M0715	Continued from page 10 During an observation of the 300 hall medication cart on 3/18/26 at 9:45 AM, with Licensed Practical Nurse (LPN) #1, revealed the following insulins were in use and either exceeded the manufacturer's 28-day room temperature storage limit or were not dated when opened: Resident #2 – Open vial of Novolog that was undated. Resident #3 – Open vial of Humalog dated 12/23/25. Resident #17 – Open vial of Insulin Aspart that was undated. Resident #51 – Humalog KwikPen that was undated. Record review of the manufacturer's storage instructions for Humalog and Novolog (Insulin Aspart) revealed that once opened, these insulins may be stored at room temperature for up to 28 days, after which the product should be discarded. On 3/18/26 at 9:52 AM, an interview with LPN #1 revealed that if insulin did not have an open date, there would be no way to determine if the insulin was still safe to administer. She stated that insulin was good for "90 days" after removal from refrigeration. LPN #1 confirmed that out-of-date insulin would not be as effective and could result in residents' blood glucose not being controlled. During an interview with the Director of Nursing on 3/19/26 at 8:32 AM, she revealed that insulins stored on the medication carts should be checked by nursing staff to ensure they are labeled with an open date and are not beyond the 28-day use period, after which they should be discarded.	M0715		
M1570	48.58.1 Infection Control The following infection control standards shall be met: 1. The facility must maintain and document an effective infection control program that protects patients, families, visitors, and facility personnel by preventing and controlling infections and communicable diseases.	M1570		

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M1570	Continued from page 11 2. The facility must have an active surveillance program that includes specific measures for prevention, early detection, control, education, and investigation of infections and communicable diseases in the facility. There must be a mechanism to evaluate the effectiveness of the program(s) and take corrective action when necessary. The program must include implementation of nationally recognized systems of infection control guidelines to avoid sources and transmission of infections and communicable diseases. 3. The facility must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on observation, staff interview, record review and facility policy review the facility failed to properly disinfect a glucometer after use, in accordance with infection control standards during one (1) of 6 (six) medication administration passes observed. Failed to provide contact isolation for 1 of five (5) residents reviewed for infection prevention measures. Resident #30 Findings Included:Review of the facility policy "Infection Control Policy for General Cleaning and Maintenance of Equipment" with revision date of 02/26 revealed that "...Critical and invasive resident care devices (e.g. (exempli gratia), glucometers) shall be cleaned and disinfected per manufacturers' recommendations...." Record Review of Policy for Control of Multidrug-Resistant Organism (MDRO) Infection,latest review date 08/21 revealed, "It is the policy of this facility to place residents in contact and/or droplet precautions if they are displaying symptoms of active multidrug-resistant organism (MDRO) infection.... An infection is considered to be active when MDROs enter the body and multiply in tissues, causing clinical manifestation of disease and immune response..." An observation on 03/18/2026 at 11:05 AM revealed that Licensed Practical Nurse (LPN) #1, failed to clean and disinfect a glucometer correctly after exiting room #311. She used a "Micro Kill Two" wipe, she wiped down the front and back of the glucometer and placed it immediately back inside the storage pouch. An interview on 03/18/26 at 11:08 AM with LPN #1, revealed that she always cleaned the glucometers after use. She revealed that she cleaned the glucometer on front and	M1570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/19/2026**

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

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M1570	Continued from page 12 back and left the machine open to air until it was dry before she placed it back in the drawer. She revealed that she was not aware that she must leave the glucometer wet for 2 (two) minutes and that she cleaned it the way she was taught in nursing school. LPN #1 revealed that the purpose of correctly cleaning glucometers was to prevent cross contamination and the possible spread of infection. An interview on 03/18/26 at 2:00 PM with Director of Nursing (DON), revealed that the nurses were supposed to clean the glucometers following each use. She revealed that they were supposed to clean the glucometer front and back and then wrap it up with the wipe for at least two minutes prior to storing it. She revealed that not cleaning the glucometer correctly could cause the spread of infection including blood borne pathogens. Record review of the Manufacturer Instructions for the "micro-kill two" germicidal wipes revealed that it disinfects hard, nonporous surfaces in 2 (two) minutes. Instructions for use revealed, "If present, use a wipe to remove visible soil prior to disinfecting. Unfold a clean wipe and thoroughly wet surface. Allow surface to remain visibly wet for contact time(s) listed on the label....." Resident #30Record review revealed a urine culture was obtained for Resident #30 on 02/24/2026 and lab reported on 03/01/2026 with culture results of "Extended-Spectrum Beta-Lactamase-Producing (ESBL)." Interview on 03/18/26 at 2:01 PM with the DON stated, "I don't remember an ESBL diagnosis, but I'll go check." Interview on 03/18/26 at 2:45 PM with LPN #2 verified that the resident was diagnosed with ESBL according to the 03/01/2026 lab report, but she confirmed that she was unaware that the resident had this diagnosis and confirmed that the resident was not on contact precautions. Interview on 03/18/26 at 3:09 PM the DON confirmed Resident #30's lab results and stated, "When I looked at the lab results, I didn't see the ESBL. I did miss that." DON confirmed that resident should be on contact precautions, but precautions were not initiated. Interview on 03/19/26 at 9:50 AM with the DON stated she has been doing the Infection Prevention (IP) role for about six (6)-eight (8) months after the nurse left and stated "I don't know what they would do if I was out. I'm the only one with IP certification and I have voiced my concerns." Record review of the Face Sheet revealed the facility admitted Resident #30 on 3/24/25 with diagnoses that included Chronic Obstructive Pulmonary Disease.	M1570		