MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17LD	A. BUILDING: _____ B. WING _____	C 07/14/2021

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) COMPLETE DATE
M 000	Initial Comments - The State Agency (SA) conducted a complaint survey, MS #17741 at the facility from 7/13/21 to 7/14/21. During the survey, the SA determined that the facility was in compliance with the Mississippi Regulations for Minimum Standards for Instutions for Aged or Infirm. The SA substantiated/ did not substantiate the complaint for Dietary Services related to food not being palatable, Quality of Care related to staffing, and Rehab services related to receiving therapy and cited no deficiencies. Census was 44.	M 000		

Mississippi State Department of Health

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