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 _____	09/17/2019

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 CI MS #15946, CI MS #16062 & CI MS #16149 The State Survey Agency (SA) conducted an annual recertification survey along with complaints MS #16062, MS #16149, and Facility Reported Incident MS #15946, from 9/15/19 to 9/17/19. The SA did not substantiate MS #16062 for Quality of Care/Injury of Unknown Origin. The SA did not substantiate MS #16149 for Quality of Care/Treatment. The SA did not substantiate Facility Reported Incident MS#15946 for Abuse. No deficiencies were cited related to the complaint survey; however, the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation and cited the regulatory deficiencies F656, F684, and F842. At the time of the survey, the census was 57, and the facility held a license for 60 beds.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §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 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	F 656		10/14/19

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

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F 656	Continued From page 1 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. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to develop a care plan related to communication between hospice nursing and the facility for one (1) of five (5) residents reviewed for hospice, Resident #35. Findings include: Record review of the facility's "Care Plan Process" policy, dated 8/17, revealed regulations require facilities to complete, at a minimum and at	F 656	1. Resident #35 care plan interventions were updated and corrected on 10/3/2019, by the Registered Nurse to ensure proper hospice documentation was completed and on medical record. 2. All hospice Residents have the potential to be affected by the deficient practice. Care plan interventions were updated and corrected by Registered Nurse, on 10/3/2019, to ensure proper hospice documentation complete on all	

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F 656	Continued From page 2 regular intervals, a comprehensive standardized assessment of each resident's functional capacity and needs. In relation to a number of specified areas (e.g., customary routine, vision, and continence). The results of the assessment, which must accurately reflect the resident's status and needs, are to be used to develop, review, and revise each resident's comprehensive person-centered plan of care. The Resident Assessment Instrument (RAI) will be used to determine guidelines for revisions and completion dates for the Comprehensive Care Plan. Review of the comprehensive care plan, for Resident #35, revealed there was no care plan developed to address the communication between the Hospice Nurse and the facility. Review of Resident #35's September 2019 Physician's Orders revealed an order for admission to Hospice for Senile Degeneration of the Brain on 11/26/18. On 09/17/19 at 10:30 AM, an interview with Licensed Practical Nurse (LPN) #3, Care Plan/Minimum Data Set (MDS) Assessment Nurse, confirmed there was no care plan intervention that addressed the Hospice nurse providing the communication notes from their visit for Resident #35 to the nursing staff at the facility. LPN #3 revealed that she will add the intervention to the care plan so that this does not happen again. LPN #3 revealed that the care plan and interventions are a guide for nursing on what care the residents require.	F 656	hospice residents medical records. 3. The Nurse Case Manager and Assessment Nurses were in-serviced by the Administrator and Director of Nursing on 10/3/2019, to ensure that all hospice residents have a care plan intervention for hospice documentation and communication weekly. Representatives of affiliated hospice companies were in-serviced by the Administrator and Director of Nursing on 9/24/19, ensuring proper hospice documentation is updated once weekly. Medical Records Nurse was in-serviced by the Administrator and Director of Nursing on 9/24/19, to ensure proper hospice documentation is updated and audited weekly. Newly admitted Hospice Resident s baseline care plan will be completed by the Assessment team and the Nurse Case Manager who serves as the Hospice Care Coordinator. 4. The Medical Records Nurse will report any findings to the Administrator and Director of Nursing in the Weekly Department Head Meeting. Any negative outcomes will be reported to the Quality Assurance Committee immediately and quarterly by the Medical Records Nurse to ensure ongoing compliance. The Quality Assurance Committee will address concerns and update corrective action plan as needed. 5. Completion Date 10/14/19	
F 684 SS=D	Quality of Care CFR(s): 483.25	F 684		10/14/19

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F 684	Continued From page 3 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to ensure communication between the hospice nurse and the facility for one (1) of five (5) residents reviewed for hospice, Resident #35. Findings include: Review of the facility's "Hospice Services" policy, dated 9/17, revealed responsibilities, policies and procedures, and payment terms must be specified in the agreement between the Hospice agency and the facility. Review of the Hospice communication binder for Resident #35 revealed the last communication from the Hospice nurse visits was dated 7/3/19. On 9/16/19 at 9:38 AM, an interview with the Director of Nursing (DON) confirmed there were no Hospice communication notes for Resident #35 since 7/3/19. The DON stated the Hospice nurses should be providing the summary of their visits to the facility, so the facility staff will know if there are any changes in condition. The DON revealed Hospice should be providing notes of their visits sooner.	F 684	1. Resident #35 hospice notes were updated and placed in the hospice binder on 9/16/19, by the hospice Registered Nurse. Resident #35 received no negative outcomes for the deficient practice. 2. All hospice Residents have the potential to be affected by the deficient practice. 3. Representatives of affiliated hospice companies were in-serviced on 9/24/19, by the Administrator and Director of Nursing, on providing current hospice documentation weekly and Care Plan Process Policy. Medical Records nurse was in-serviced on 9/24/19, by the Administrator and Director of Nursing to ensure hospice documentation is updated weekly. 4. The Medical Records Nurse will report findings to the Administrator and Director of Nursing in the Weekly Department Head Meeting. Problems identified will be reported to the Quality Assurance Committee immediately and then quarterly by the Medical Records Nurse to ensure ongoing compliance. The Quality Assurance Committee will address concerns and update corrective action	

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F 684	Continued From page 4 On 09/16/19 at 9:43 AM, an interview with Licensed Practical Nurse (LPN) #1 confirmed there were no notes in the Hospice Binder for Resident #35 since 7/3/19. LPN #1 revealed she had talked to the Hospice service about the need to get the communication notes to the facility and in the binder. On 09/16/19 at 10:01 AM, an interview with the (Local) Hospice Registered Nurse (RN) confirmed there were no visits noted from the Hospice nurse in the Hospice binder since 7/3/19. The (Local) Hospice RN confirmed the Hospice services provided a nurse to the facility at least weekly, and usually more often, and a summary of the visit is prepared to provide to the facility for communication purposes. The (Local) Hospice RN revealed she is the nurse that places the communication notes in Resident # 35's Hospice binder. The (Local) Hospice RN revealed the Hospice Management Office prints the notes off and gives them to the RN to place on the Binder and she does not know why they had not printed off the notes since 7/3/19. Review of Resident #35's physician's orders revealed an order written on 11/26/18, for admission to the local Hospice.	F 684	plan when needed. 5. Completion Date 10/14/19	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent	F 842		10/14/19

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F 842	Continued From page 5 agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained	F 842		

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F 842	Continued From page 6 for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to ensure that the medical records were accurate for a discontinued medication for one (1) of five (5) residents reviewed for unnecessary medications, Resident #49. Findings include: Review of the facility's "Medical Records" policy, revealed, "This facility maintains a separate resident record on each resident in accordance with regulations and accepted professional standards and practices that are complete, accurate, readily accessible, and systematically organized. Review of the physician's order, dated 7/26/19,	F 842	1. The Trazadone was discontinued from the Medication Administration Record and the Medical Doctor was notified by the Director of Nursing for Resident #49 on 9/16/19. 2. All residents have the potential to be affected by the deficient practice. All physicians orders were audited on 9/16/19 by Registered Nurses and Licensed Practical Nurses to check orders for non-compliance and no problems were noted. The medication carts were audited on 9/16/19, by the Medical Records Nurse for any discontinued meds and no problems were noted. 3. All nurses were in serviced by the Director of Nursing on 9/21/19, regarding transcription of Physicians orders to the	

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F 842	Continued From page 7 revealed a hand written order to discontinue (D/C) Trazodone, signed by the Medical Doctor. Review of nurse's notes, dated 7/26/19, at 03:14 PM, revealed the (Medical Doctor) was here in the AM and visited with the resident. A new order noted to discontinue Trazodone. Faxed to pharmacy. Signed by Licensed Practical Nurse #2. Review of the July 2019 Physician's Orders revealed that there were two (2) separate orders for Trazadone. An order dated 9/12/18, read "Trazodone 50 mg tablet - take one half (1/2) tablet by mouth daily at 5 PM". The second order dated 12/27/18, read "Trazodone (Desyrel) 50 mg tablet - give one (1) tablet by mouth every bedtime (qhs)...". Review of the August 2019 and September 2019 physician's orders revealed the 12/27/18 order remained on the physician's orders. Interview with the Pharmacist on 9/16/19 at 5:42 PM, revealed the pharmacy received an order to discontinue Trazodone for Resident #49 on 7/26/19. She stated Trazodone was last filled by the pharmacy on 7/22/19, for a 14 day supply with 21 tablets. She stated both doses were on one (1) card and there were 28 bubbles. Review of the Prescription Drug Inventory for Destruction revealed 25 Trazodone tablets were destroyed by Pillverizer on 7/29/19. On 09/16/19, at 5:00 PM, in an interview with the Director of Nursing (DON), she stated that Trazodone was taken off the cart and destroyed and that Resident #49 did not receive any	F 842	computer, follow-up to the appropriate tasks and documentation of medications with appropriate administration of medications. Policies reviewed were Drug Administration and Documentation and Administration of Medications. All facility nurses who documented giving the medication were educated and given a disciplinary action by the Director of Nursing and Administrator. All facility nurses and agency nurses, who documented giving the medication, will have a Monitoring Medication Pass review done with Director of Nurses by 10/14/19. 4. All medication orders will be reviewed daily by the Medical Records department to ensure that orders are transcribed correctly and discontinued medications are removed from the medication cart. Any negative findings will be reported to the Director of Nurses and Administrator by the Medical Records Nurse during daily Stand- up Meeting. Negative findings will be reported to the Quality Assurance Committee immediately and quarterly by the Medical Records Nurse to ensure ongoing compliance. The Quality Assurance Committee will address concerns and update the corrective action plan when needed. 5. Completion Date 10/14/19	

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F 842	Continued From page 8 Trazodone after 7/25/19, but confirmed the order was still in the record. Interview with Registered Nurse (RN) #1, on 09/17/19 09:14 AM, revealed she worked the evening shift on 8/30/19, and she recalled the Trazodone not being on the cart or in the med room. She stated that she went back to the cart to document Trazodone not administered and the computer died. She took it to the nurse's station to charge and when it came back up she documented administered. She stated, "It was just so much going on I didn't think to go back to it". On 09/17/19, 09:40 AM, an interview with LPN #1/Medical Records, revealed nurses on the floor are responsible for taking the medications out of the cart. LPN #1/Medical Records confirmed the order for Trazodone was still in the medical record and should have been removed. On 09/17/19 at 10:05 AM, interview with LPN #2 confirmed she took the order for D/C Trazodone on 7/26/19, faxed it to the pharmacy, pulled the med off the cart so nobody would have given it accidentally, and entered the order in the computer. She stated that she discontinued the Trazodone in the computer; but, sometimes the computer glitches and jumps. She stated she doesn't work the night shift so she wasn't aware of the two (2) separate Trazodone orders. She stated that she removes any discontinued medications from the med cart.	F 842		

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K 000	INITIAL COMMENTS CFR 48.70(a) The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000		

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E 000	Initial Comments *EMERGENCY PREPAREDNESS* Survey conducted on 09/17/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were cited.	E 000		

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