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
	16WH	A. BUILDING: _____ B. WING _____	C 06/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK OF COLLINS	1315 SOUTH FIR AVE COLLINS, MS 39428

(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 640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This Statute is not met as evidenced by: Based on staff interviews, record review, and facility policy review, the facility failed to complete an investigation for a resident who had a fall. Resident #103. Findings Include: A record review of the facility's policy "Fall Prevention and Management Program", revealed, "...Management...Should falling occur...the underlying cause will be investigated..." A record review of "Departmental Notes" for Resident #103, dated 12/2/2021 at 7:27 AM, revealed, "Resident noted on floor on his bottom by CNA (Certified Nursing Assistant)..." A record review of the facility's "Incident Log" with dates of incidents listed from 12/1/21 through 6/6/22 revealed there was no fall listed for Resident #103 on 12/2/2021. On 6/8/22 at 1:05 PM, in an interview with the Director of Nursing (DON), she stated she had not been made aware that Resident #103 had a fall on 12/2/21. She verified the nurse who authored the Departmental Note for Resident #103 was an agency nurse and she is no longer working at the facility. The nurse, Licensed Practical Nurse (LPN) #3, did not communicate to	M 640	-Resident #103 was discharged from the facility on 12/8/2021. -All residents with incidents have the potential to be affected by the deficient practice. -An in-service was initiated on 06/8/2022 with facility Registered nurses, Licensed Practical Nurses, Certified Nursing Assistants, Temporary Aides, Housekeeping, Activities, Dietary, Social, and Office staff by Director of Nursing. Topics reviewed included Incident Investigation and Reporting; Fall Prevention and Management. An audit was completed on 06/9/2022 by Facility Administrator of active incident/accident reports. All reports audited on 06/9/22 by Facility Administrator had appropriate investigations as indicated. -The facility Director of Nursing and/or Facility Administrator will review active residents nurse notes five times per week for three weeks beginning on 06/09/2022 then weekly for two weeks until substantial compliance is attained to ensure incident/accident reports are investigated timely.	7/5/22

Mississippi State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/30/22

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M 640	Continued From page 1 the DON that the resident had fallen. On 6/8/22 at 1:50 PM, in an interview with the DON, she stated that the protocol used when a fall occurs is that the nurse will complete an incident report and place the information in a box at the nurses station. The DON will retrieve the incident information from the box, follow up on the incident, and forward the information to the Administrator. The staff will discuss incidents and accidents in the weekly High Risk Management Committee Meetings, and Resident #103's fall was never discussed in the meetings. She confirmed LPN #3 had received training on the protocol for incidents and accidents. A record review of the "High Risk Management Committee Meetings" dated 12/1/21 and 12/8/21 revealed Resident #103's fall was not discussed at the weekly meetings. A record review of Resident #103's "Face Sheet" revealed the facility admitted him on 11/26/21, with diagnoses including Muscle Weakness, Lack of Coordination, and Need for Assistance with Personal Care. A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/2/21 revealed Resident #103 had a Brief Interview of Mental Status (BIMS) score of nine (9), which indicated he had moderate cognitive impairment. A record review of the "Contract Caregiver Staff Orientation Checklist", revealed LPN #3 signed the checklist on 9/21 which included "Accident and Incident Reporting".	M 640	A quality Assurance Committee meeting was held on 06/27/2022 to review this corrective action plan. The Quality Assurance Committee members present on 06/27/2022 were Facility Administrator, Facility Director of Nurses, Facility Medical Director, Facility Infection Preventionist, Dietary Manager, Environmental Services Supervisor, MDS Nurse, Accounts Manager, Admission Coordinator, Social Services, and Medical Records Nurse. The facility Quality Assurance Committee Meeting shall be held monthly for 2 months until substantial compliance is attained. Areas of concern will be carried the the Quality Assurance Committee for corrective action to include in-service training, and/or disciplinary action.	