STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255215	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) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification and two (2) Complaint Investigations CI MS# 18383 and CI MS #18764 at the facility from 6/05/22 through 6/08/22. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid. The SA did not substantiate CI MS #18764 for an unknown injury. The SA substantiated CI MS #18383 regarding safety/falls and cited F610. The SA also cited F636, F657, F686 and F812 related to the survey. The facility held a license for 60 beds with a census of 57.	F 000		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced	F 610		7/5/22

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

Electronically Signed | 06/30/2022

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F 610	Continued From page 1 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 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	F 610	-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. 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,	

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F 610	Continued From page 2 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".	F 610	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.	
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment.	F 657		7/5/22

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F 657	Continued From page 3 (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to ensure the comprehensive care plan was reviewed timely for one (1) resident, Resident #39, and revised for two (2) residents, Resident #39 and Resident #103, out of four (4) residents sampled for falls. Findings Include: Review of the facility's policy, "Care Plan Process" with a revision date of 08/17 revealed, "...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	F 657	-Resident #34 comprehensive care plan was reviewed and revised on 06/09/2022 by Nurse Case Manager. Resident #103 was discharged from the facility on 12/08/2022. -All residents with falls have the potential to be affected by the deficient practice. -An in-service was initiated on 06/07/2022 with facility Assessment Nurse and Nurse Case Manager by Director of Nursing. Topics reviewed included Care Plan Process with review and revision of resident comprehensive care plans. An	

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F 657	Continued From page 4 plan of care...Re-evaluates the resident's status at prescribed intervals (i.e. quarterly, annually, or if a significant change in status occurs)...Interventions are actions that should promote meeting the established goal..." Review of the facility's policy "Fall Prevention and Management Program" with the latest revision date of 09/18 revealed, "...will be used to develop interventions after each fall and for care plan revisions...Management...The resident's care plan is updated to reflect the new intervention(s). Resident #103 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 "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 Resident #103's "Baseline Care Plan And Summary" reflected actual falls dated 11/30/21 and 12/7/21, along with the interventions. There was no fall with an intervention for the fall that occurred on 12/2/2021.	F 657	audit was completed on 06/09/2022 by Director of Nursing and Nurse Case Manager of resident care plans for revisions and fall interventions. Care plans were reviewed and updated on 06/09/2022 to include interventions. -The facility Director of Nursing and/or Facility Administrator will review comprehensive care plans for fall interventions weekly for three weeks beginning on 06/09/2022 then monthly times two months until substantial compliance is attained to ensure timely reviews with fall interventions. 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.	

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F 657	Continued From page 5	F 657		

A record review of the medical record revealed there was no comprehensive care plan developed related to falls for Resident #103.

On 6/8/22 at 1:50 PM, in an interview with the DON, she stated the care plan should have been updated on 12/2/21 to include Resident #103's fall. The care plan is used by staff to give care to the residents.

Resident #34

Record review of the "Face Sheet" revealed Resident #34 was admitted by the facility on 10/2/2019 with diagnoses including Hyperlipidemia, Chronic Obstructive Pulmonary Disease with Acute Exacerbation, and Chronic Respiratory Failure with Hypoxia.

Record review of the Quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 4/25/22 revealed Resident #34 had a Brief Interview of Mental Status (BIMS) score of 15, which indicated she is cognitively intact.

Record review of Resident #34's "Incident Log" dated from 12/6/21 through 6/6/22 revealed she had falls that occurred on 12/15/21, 2/4/22, 3/26/22, 3/29/22, 4/10/22, 5/10/22.

Record review of Resident #34's care plan revealed a "Problem/Need" listed as "Resident is

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F 657	Continued From page 6	F 657		

at risk for falls" with dates of actual falls listed as 11/12/19, 3/6/21, and 2/4/22". There were no actual fall dates listed for the falls that occurred on 12/15/21, 3/26/22, 3/29/22, 4/10/22, and 5/10/22. The "Goal & Target" date was listed as "Resident will be free of injury and complications through the next review 8-25-21" and "Resident will have no falls through next review 8/25/21", which indicated Resident #34's status had not been re-evaluated with the results of the latest MDS assessment dated 4/25/22. Care plan approaches related to the falls corresponded with the date of the actual falls on 3/6/21 and 2/4/22. There were no approaches listed for the actual falls that occurred on 12/15/21, 3/26/22, 3/29/22, 4/10/22, and 5/10/22.

On 06/07/22 at 11:17 AM, in an interview with Registered Nurse (RN) #1 and Licensed Practical Nurse (LPN) #1, RN #1 confirmed Resident #34's care plan was not reviewed timely and that typically the care plan is reviewed with each assessment. The care plans are located in each resident's chart and updates are handwritten until the next comprehensive MDS assessment, in which the entire care plan is reprinted and placed on the chart. She confirmed the care plan should be revised with each fall to include the date the fall occurred and the corresponding intervention.

On 06/08/22 at 10:09 AM, in an interview with the Director of Nursing (DON), she stated that it is her expectation that the care plan be reviewed with each MDS, which is at least quarterly. She stated falls are reviewed daily in morning meeting and interventions are discussed. The care plan should be updated at that time with the intervention. The interventions discussed in the morning meetings for Resident #34 "did not make

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F 657	Continued From page 7 it to the resident's care plan in the chart". She acknowledged that the care plan is used by the staff to know how they are to provide care to the residents.	F 657		