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	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark of Collins	1315 South Fir Ave Collins, MS 39428

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, and facility policy review, the facility failed to remove expired food items from the refrigerator by the manufacturer's expiration date, maintain the refrigerator in a clean condition free from spills, and store food according to manufacturer's instructions for one (1) of four (4) survey days.Findings include:A review of the facility's policy, Food Storage Labeling revised August 2024, revealed, .The facility will ensure the safety and quality of food by following good storage procedures.Procedure.7. Recommended Food Storage Chart.c. Steps to use the chart.iii. Use the calendar to select the recommended date to discard.d. discard foods that are found to have exceeded their storage time.8. Rotation a. First In, First Out method is used to rotate food in all storage areas i. Identify the food item's use by date or expiration date .On 09/15/2025 at 10:18 AM, during the initial tour of the dietary department with the Dietary Manager (DM), a gallon of whole milk in cooler #3 was observed with a manufacturer's expiration date of 09/14/2025. The floor of the refrigerator was unclean and contained dried milk residue. The DM stated dietary aides are responsible for checking expiration dates and cleaning spills as they occur. A bottle of low-sodium soy sauce was also observed stored on a shelf above the sink despite manufacturer instructions indicating it must be refrigerated after opening. The DM acknowledged the finding and stated she was unaware soy sauce required refrigeration after opening.On 09/18/2025 at 1:36 PM, during an interview, the Administrator stated that it was his expectation that the dietary department ensure proper food storage and monitoring of expiration dates.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation and staff interview, the facility failed to handle residents' clean clothing in a manner that prevented the possible spread of infection for one (1) of four (4) days of survey.Findings include:On 9/15/25 at 2:50 PM, during an observation and interview with Laundry Worker (LW) #1, she was delivering clean clothes to residents' rooms while holding the clothes close to her body, so that the clothes touched her uniform during four (4) delivery stops. LW #1 stated she had been trained not to allow residents' clothing to touch her clothing, as this could spread germs and infection. She reported that staff were in-serviced monthly on infection control practices.On 9/18/25 at 9:33 AM, during an interview with the Infection Prevention (IP) Nurse, she acknowledged that LW #1 failed to handle the clean laundry in a manner that would prevent infection. The IP Nurse stated she provided monthly in-service training on infection control and expected staff to follow guidelines to keep clean clothing away from their uniforms.On 9/18/25 at 9:37 AM, during an interview with the Administrator, he acknowledged that he was made aware that a laundry worker had allowed residents' clean clothing to touch her uniform during transport. He stated that his expectation was for clothes to be washed and covered during delivery to prevent contamination.