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	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark of Desoto	3068 Nail Road West Horn Lake, MS 38637

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 47158 Based on observation, staff interview, and facility policy review, the facility failed to provide privacy for one (1) of 20 residents reviewed as evidenced by a resident who was left uncovered and visible from the hallway. Resident # 17 Findings Include: A review of the facility's Dignity and Respect policy, revised on 7/22, stated: A facility must treat each resident with dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of their quality of life, recognizing each resident's individuality. The facility shall protect and promote the rights of the resident . Residents will be examined and treated in a manner that maintains bodily privacy . An observation from the hallway on 10/28/24 at 9:30 AM, revealed Resident #17's door was open and was lying in bed uncovered, with an adult incontinence brief on the resident, stomach exposed, with the Percutaneous Endoscopic Gastrostomy (PEG) tube visible. In a follow-up observation from the hallway on 10/28/24 at 9:55 AM, Resident #17 was still lying uncovered in bed, with an adult brief, stomach, and PEG tube exposed, and with the door open and privacy curtain pulled back. An observation and interview on 10/28/24 at 10:20 AM, with Licensed Practical Nurse (LPN) #1 confirmed that Resident #17's door and privacy curtain were open and that the resident was in bed uncovered, with their hospital gown partially up, revealing an adult brief. The LPN stated that the resident never stays covered but acknowledged that staff should be keeping the privacy curtain pulled so that the resident was not visible from the hallway. In an interview on 10/29/24 at 9:00 AM, the Director of Nursing (DON) confirmed that Resident #17 being uncovered, with the brief and PEG tube visible from the hallway, was a dignity concern. Record review of the Admission Record revealed the facility admitted Resident #17 on 7/27/22 with a diagnosis of Cerebral Infarction.

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

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	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark of Desoto	3068 Nail Road West Horn Lake, MS 38637

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47874 Based on resident and staff interview, record review, and facility policy review, the facility failed to honor a resident's right to make health care decisions related to cardiopulmonary resuscitation (CPR) for one (1) of 20 sampled residents. Resident #58 Findings Include: Review of the facility policy titled Advance Directives with a revision date of ,d+[DATE] revealed under, Policy: The facility recognizes that all adults have a fundamental right to make decisions relating to their own medical treatment, including the right to accept or refuse medical care. Also revealed under, Procedure: . The resident will be encouraged to participate in all aspects of decision-making regarding care and treatment. Statements by a competent resident regarding his/her desire to accept or refuse treatment will be documented in the resident's clinical record. Record review of the Advanced Directive Consent for Resident #58 revealed, the consent was initialed and signed by a family member dated [DATE] and that Resident #58 did not sign the consent. An interview with Resident #58 on [DATE] at 8:10 AM, revealed the facility had not gone over the advanced directives consent or code status with her. She revealed she would like to make her own healthcare decisions because she was still able. She confirmed she did not have a medical Power of Attorney (POA) established and explained she wanted everything done to save her life, should something happen. An interview with the Admission Coordinator on [DATE] at 8:24 AM, confirmed she did not go over the advanced directives and code status with Resident #58 on admission. She explained that she allowed a family member to sign the consent because the family member was the Resident Representative (RR). The Admission Coordinator confirmed she should have spoken with the resident regarding her wishes. She revealed Resident #58 was cognitive and able to make her own healthcare decisions, and she did not have a medical POA to make decisions for her. An interview with the Administrator on [DATE] at 8:56 AM, confirmed Resident #58 was cognitive and should have been allowed to sign her consent related to code status on admission. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] revealed under, section C, a Brief Interview for Mental Status (BIMS) summary score of 12, which indicated Resident #58 was moderately cognitively impaired. Record review of the Admission Record revealed the facility admitted Resident #58 on [DATE].

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	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark of Desoto	3068 Nail Road West Horn Lake, MS 38637

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 0656 Level of Harm - Actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 47158 Based on observation, staff interviews, record review, and facility policy review, the facility failed to develop a comprehensive care plan for a resident with pressure ulcers for two (2) of 20 sampled residents. Resident # 28 and Resident # 209 Findings Include: Review of the facility policy titled Care Plan Process with a revision date of 8/17 revealed, .The Care Plan must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . Resident #28 A review of the Skin & Wound Evaluation dated 9/19/24 revealed that Resident #28 acquired an unstageable pressure ulcer on the right fourth (4th) ring finger on 9/19/24. The quarterly Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 9/16/24 indicated that Resident #28 had a functional limitation in the range of motion (ROM) in the upper extremity on one side. A review of the comprehensive care plan for Resident #28 showed that no pressure reduction interventions were in place to reduce the risk of pressure ulcers associated with the resident's right fourth finger. On 10/29/24 at 8:30 AM, during an interview with the Wound Treatment Nurse she explained that Resident #28 had developed a pressure ulcer on the right fourth ring finger due to pressure from fingers contracted in a fist. She acknowledged that pressure relief measures should have been implemented to prevent pressure ulcers on Resident #28's fingers. During an interview with MDS Nurse #1 and MDS Nurse #2 on 10/29/24 at 8:45 AM, they stated that the purpose of the care plan is to inform staff of the resident's required care. They confirmed that there was no care plan in place to prevent skin breakdown related to the right-hand contracture and agreed that such a plan should have been established. Record review of the Admission Record revealed the facility admitted Resident # 28 on 5/31/21 with a diagnosis of Cerebral Infarction. Resident #209 On 10/29/24 at 11:20 AM, an interview with the Wound Treatment Nurse revealed, Resident #209 had a new pressure wound on the right Achillies area. (continued on next page)

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	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark of Desoto	3068 Nail Road West Horn Lake, MS 38637

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 0656 Level of Harm - Actual harm Residents Affected - Few	Record review revealed a care plan was not developed for Resident #209's wound care or pressure ulcer on the right Achilles. On 10/29/24 at 3:50 PM, an interview with the Administrator (ADM) confirmed Resident #209's wound care plan was not developed. An interview with the MDS Nurse #1 on 10/30/24 at 10:40 AM revealed the purpose of care plan development was so that anyone who looks at the wound knew the level of care needed. Record review of the Admission Record revealed the facility admitted Resident #209 on 10/9/24 with a medical diagnosis of Displaced Fracture of the Lower Epiphysis of Right Femur. 47874

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	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark of Desoto	3068 Nail Road West Horn Lake, MS 38637

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 47158 Based on observation, record review, resident and staff interview the facility failed to provide treatment and services to prevent pressure ulcers for two (2) of five (5) residents observed with pressure ulcers. Resident #28 and Resident # 209 Findings Included: Record review of facility policy Pressure Ulcer Prevention and Treatment Intervention Guidelines, revised 10/22, revealed C. Protection from Fiction or Shear .4. Provide padding for casts, braces, splints, oxygen tubing, shoes etc. as needed to prevent friction. 5. Remove orthotics on a regular basis for skin inspection . Therapy Department Interventions .3. Explore possible therapy interventions for .c. Splinting/orthotic modifications . 1. Provide pressure ulcer topical treatments as ordered Resident #28 A review of the Skin & Wound Evaluation dated 9/19/24, revealed that Resident #28 acquired an unstageable pressure ulcer on the right fourth (4th) ring finger on 9/19/24. Record review revealed measurements of 1.4 centimeters (cm) area, 1.4 cm length, 1.3 cm width and depth not applicable (n/a). The quarterly Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 9/16/24 Section GG revealed revealed Resident #28 had a functional limitation in the range of motion in the upper extremity on one side. A record review of Order Listing Report for September and October 2024 revealed no orders for pressure relief devices for Resident # 28. During an observation and interview with Licensed Practical Nurse (LPN) #2 on 10/29/24 at 8:00 AM, Resident #28 was observed with a palm shield in place on the right hand. LPN #2 confirmed that Resident #28 had a contracture in the right hand and stated that the palm shield was applied only after the pressure ulcer developed on the right 4th ring finger. She verified that no splinting or other pressure relief interventions were in place before the pressure ulcer developed. In an interview with the Wound Treatment Nurse on 10/29/24 at 8:30 AM, she explained that Resident #28 had developed a pressure ulcer on the right fourth ring finger due to pressure from the fingers being contracted in a fist. She stated that when she identified the pressure ulcer, she contacted therapy to request a pressure relief device. She acknowledged that pressure relief measures should have been in place to prevent pressure ulcers on Resident #28's fingers. She confirmed that there were no orders or documentation for the use of the palm shield. In an interview with the Rehabilitation Director on 10/30/24 at 9:00 AM, she verified that Resident #28 did not have a palm shield before developing the pressure ulcer on the right 4th finger and confirmed that she was consulted, and the shield was implemented after the ulcer appeared. Record review of the Admission Record revealed the facility admitted Resident # 28 on 5/31/21 with a diagnosis of Cerebral Infarction. (continued on next page)

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	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark of Desoto	3068 Nail Road West Horn Lake, MS 38637

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 0686 Level of Harm - Actual harm Residents Affected - Few	Resident #209 An observation and interview with Resident #209 on 10/29/24 at 10:16 AM revealed, she was lying in bed with an immobilizer to the right leg. The resident verbalized she had an unrepaired femur fracture and revealed she had a new sore that developed under the brace since she admitted . She explained that she followed up with her orthopedic doctor last week, and he asked her to use foam under the brace, but the facility did not have any foam. An interview with the Wound Treatment Nurse on 10/29/24 at 11:20 AM revealed Resident #209 had a new pressure wound caused by the immobilizer on the Achilles area. She explained that she was notified by the Therapy Rehab Director on 10/21/24 that the residents' immobilizer was sliding down and had caused a sore. She revealed she had been treating the wound since she was made aware, but the treatment order was not added to the Treatment Administration Record (TAR) until 10/26/24, and she had not staged the wound. The Wound Nurse confirmed Resident #209's skin had not been assessed under the immobilizer every day to determine if the resident had any skin breakdown. Record review of the Wound Evaluation dated 10/22/24 revealed the wound to the right Achilles was not staged and measured 0.94 cm in length and 0.56 cm in width, with no determination on depth. Review of the October 2024 Treatment Administration Record for Resident #209 revealed an order, dated 10/26/24, Clean open area to right heel with NS (normal saline) and pat dry, apply Xeroform and cover with bandage every other day until resolved with a discontinue date of 10/29/24. Also revealed an order, dated 10/29/24, Clean open area to right Achilles with NS (normal saline) and pat dry, apply TAO (triple antibiotic ointment) and cover with bandage every other day until resolved. Record review of the Order Listing Report revealed there was not a physician order for Resident #209's leg immobilizer or to monitor the skin under the brace for skin breakdown. An interview with the Director of Nursing (DON) on 10/29/24 at 12:50 PM confirmed, Resident #209 did not have an order for the right leg immobilizer. She revealed it was not clear to her why the staff would not have called and followed up on how the resident was supposed to wear it. Record review of the Physician Consultation Report dated 10/24/24 revealed under, Findings: . Pressure sores where hinges are present. Also revealed under, Recommendations: When pt is in bed open brace completely to relieve pressure; Apply thin layer of foam to posterior calf and thigh portion of brace. An interview with the Wound Treatment Nurse on 10/29/24 at 2:30 PM confirmed she did not implement the orders recommended by the Orthopedic Physician. She revealed the foam would have been too thick under the brace and stated, I don't think foam would work. She revealed Resident #209 had told her the hospital applied foam under the immobilizer, and it was too tight. An interview with the Administrator (ADM) on 10/29/24 at 2:48 PM, confirmed the skin should be assessed underneath an immobilizer daily to ensure there was no skin breakdown caused by the device. She confirmed Resident #209's wound was avoidable, if the skin under the immobilizer had been assessed. She revealed the physician's recommendations should have been followed. (continued on next page)

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	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark of Desoto	3068 Nail Road West Horn Lake, MS 38637

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 0686 Level of Harm - Actual harm Residents Affected - Few	An interview with the Therapy Rehab Director on 10/30/24 at 9:10 AM revealed she usually had to take Resident #209's immobilizer off to reposition it correctly. She revealed she observed the area to the resident's leg and reported it to the nurse on duty on 10/20/24. She stated the nurse thought the brace had rubbed the area on the leg, and she needed something to pad the area for support. The therapist revealed they placed a towel under the brace that day for extra protection, and she told the Wound Treatment Nurse the following day. An interview with the Wound Treatment Nurse on 10/30/24 at 10:25 AM confirmed Resident #209's wound was avoidable if the proper monitoring under the brace had been done. Record review of the Admission Record revealed the facility admitted Resident #209 on 10/9/24 with a medical diagnosis of Displaced Fracture of the Lower Epiphysis of Right Femur. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/16/24 revealed under, section C, a Brief Interview for Mental Status (BIMS) summary score of 15, which indicated Resident #209 was cognitively intact. 47874

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	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark of Desoto	3068 Nail Road West Horn Lake, MS 38637

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47157 Based on observation, staff interview, record review, and facility policy review, the facility failed to provide appropriate care services for (1) one of (5) resident care observations. (Resident # 57) Findings include: A review of the facility policy titled, Perineal Care, latest revision date 01/24 revealed.Resident with Catheter: 4.) Using a clean washcloth or wash wipe, start at the meatus and wash the tubing in a circular motion away from the body . Rinse using the same method . An observation of catheter care with Certified Nurse Assistants (CNA) #1 and CNA #2 for Resident #57 on 10/29/24 at 11:34 AM, revealed CNA #1 cleaned one side of the urinary catheter from the urinary meatus downward with a clean soapy wet washcloth, and then cleaned the other side with a clean area section of the washcloth. CNA #1 then placed the dirty washcloth into the clean water in the wash basin, rinsed it out and used the same dirty washcloth to rinse the urinary catheter tubing/urinary meatus all in the same swipe wearing the same gloves worn during cleaning process In an interview with CNA #2 on 10/29/24 at 11:56 AM, she revealed that she was in the room only to help CNA #1 if she needed any help. She confirmed that CNA #1 contaminated the clean water in the basin when she put the dirty washcloth in it. She then stated CNA #1 should also have used a clean washcloth to rinse the resident. In an interview with CNA #1 on 10/29/24 at 11:59 AM, she revealed she did not even realize she forgot to change her gloves as well as she used the same dirty washcloth to rinse Resident #57's meatus and catheter tubing. She stated that it was cross contamination and could lead to infections. In an interview with the Infection Control/Treatment Nurse on 10/29/24 at 12:12 PM, she revealed that the CNA should have performed hand hygiene and used a clean washcloth to rinse the perineal area after cleansing the resident to prevent cross contamination of bacteria. She stated that failing to do this could lead to urinary tract infections for the resident. Record review of the Admission Record revealed the facility admitted Resident # 57 on 9/16/24 with diagnoses including Neuromuscular dysfunction of the bladder. Record review of Resident #57's Section C of the Minimum Data Set (MDS) dated [DATE] revealed on a Brief Interview for Mental Status (BIMS) score was 15, indicating the resident was cognitively intact. In Section H Bladder and Bowel item H0100 revealed the resident had an indwelling urinary catheter.

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	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark of Desoto	3068 Nail Road West Horn Lake, MS 38637

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 47157 Based on observation, staff interview, record review, and facility policy review, the facility failed to maintain a system of medication records that enables periodic accurate reconciliation and accounting for all controlled medications for (1) one of (3) three narcotic storage areas reviewed. Findings include: A review of the facility policy titled, Drug-Controlled Substances, latest revision 11/17 revealed, Regulations require that the facility have a system in place to account for the receipt, usage, disposition, and reconciliation of all controlled medications . A controlled drug count is to be done at the beginning of each shift by the outgoing and on-coming nurses . An observation of the narcotic box in the medication room refrigerator with Licensed Practical Nurse (LPN) # 1 on 10/29/24 at 8:30 AM, revealed four (4) vials of Emergency Drug Kit (EDK) Lorazepam two (2) mg/ml (milligram/milliliter). LPN #1 revealed she and the other medication nurse on duty have access to the narcotic box in the refrigerator. She then confirmed the Lorazepam was not counted every shift with the other narcotics on the medication carts with the ongoing and off going shifts. LPN #1 also revealed she was unaware how long the Lorazepam vials had been in the refrigerator. In an interview with the Pharmacy Consultant on 10/29/24 at 8:35 AM, he confirmed that the medication nurses should be reconciling the EDK Lorazepam in the medication room narcotic box every shift. He then revealed that a potential concern from not reconciling narcotics is potential narcotic diversion. In an interview with LPN #2 on 10/29/24 at 10:10 AM, she stated she has a key to the narcotic lock box in the medication room refrigerator and was aware there was Lorazepam in the narcotic box. She then confirmed that the Lorazepam was not reconciled every shift with the other narcotics on the medication cart and is not listed in her narcotic count book. She stated a concern from not counting the narcotic every shift was it could have been missing, and we would not know when it went missing. A review of an Emergency Box Requisition form with the Pharmacy Consultant on 10/29/24 at 10:20 AM, revealed the four vials of Lorazepam in the medication room lock box were delivered on 5/04/23. He revealed after further observation of the Lorazepam, the EDK requisition form to be counted each shift was still in the refrigerator with the box of Lorazepam vials. The pharmacy Consultant then confirmed the Lorazepam was never added to either medication cart-controlled record books for the nurses to reconcile every shift. In an interview with the Director of Nursing (DON) on 10/29/24 at 10:30 AM, she confirmed the EDK Lorazepam should have been added to the narcotic count book to be counted each shift.

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	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark of Desoto	3068 Nail Road West Horn Lake, MS 38637

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 47874 Based on observation, resident and staff interview, and facility policy review, the facility failed to ensure a resident's environment was free from accident hazards, as evidenced by, medications left at bedside for one (1) of twenty sampled residents. Resident #58 Findings Include: Review of the facility policy titled Medication Storage with a revision date of 11/17 revealed under, There shall be storage areas provided that assure adequate space, equipment and security for medications within the facility . An observation and interview on 10/28/24 at 9:50 AM, revealed Resident #58 lying in bed and on the bedside table was a six (6) ounce bottle of red spray liquid with a label that read, Sore Throat Spray and a one (1) fluid ounce white bottle that read, Lubricating Eye Drops. The resident revealed that she used the eye drops about six times a day for dry eyes and administered it herself. She revealed that she used the sore throat spray as needed for a sore throat. She explained the staff knew she had it because it had been on the table since she was admitted to the facility. An interview with Licensed Practical Nurse (LPN) #1 on 10/28/24 at 10:30 AM, confirmed Resident #58 had medications at her bedside. She revealed the resident did not have a physician order for the medication and the resident could be using the medication too often without staff monitoring, or a confused resident could come along and take it. An interview with the Administrator (ADM) on 10/29/24 at 8:58 AM, revealed the residents were not supposed to have medications at bedside. She confirmed Resident #58 could take too much, or she could have a reaction to the medications, and that all medications should be secured and put away. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/10/24 revealed under Section C, a Brief Interview for Mental Status (BIMS) summary score of 12, which indicated Resident #58 was moderately cognitively impaired. Record review of the Admission Record revealed the facility admitted Resident #58 on 10/4/24 with a medical diagnosis of Cellulitis of the left lower leg.

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	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark of Desoto	3068 Nail Road West Horn Lake, MS 38637

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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 47158 Based on staff interviews and record reviews, the facility failed to submit accurate direct care staffing information to the Centers for Medicare and Medicaid Services (CMS) as required for the third quarter (Q3) of fiscal year (FY) 2024 (April 1-June 30). Findings include: Record review of a letter, on facility letter head, signed by the Administrator, revealed that the facility does not have a policy related to Payroll Based Journal (PBJ) submission. A record review of the facility's PBJ Staffing Data Report for Q3 FY 2024 revealed that the facility triggered for excessively low weekend staffing. In an interview on 10/29/24 at 12:45 PM, the Administrator stated that the facility had not submitted accurate PBJ staffing data to CMS for the third quarter of FY 2024. She explained that the corporate office was responsible for submitting PBJ staffing data for the facility; she provided the agency/contract staffing hours, while the corporate office pulls hours for facility staff from payroll records. She noted that administrative staff were sometimes reassigned to provide direct resident care when there are call-ins, but there was currently no way to report this as direct care, which contributed to the PBJ reporting error.