STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255320	A. Building B. Wing	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark Nursing and Rehab Center	100 Lauren Drive Booneville, MS 38829

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41878 Based on observation, staff, resident, and resident representative (RR) interviews, record review, and facility policy review, the facility failed to ensure a resident's right to be free from abuse for one (1) of seven (7) residents sampled. Resident #1 Findings include: Record review of facility policy titled, Abuse, Neglect, and Exploitation, with revision date of 10/10/22, revealed, This facility's policy is to protect each resident's health, welfare, and rights by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property . Abuse means the willful infliction of injury . Record review of the Facility Investigation Final Report to the State Agency and Attorney General dated 2/25/25 revealed that on 2/20/25 at approximately 2:30 AM, the Director of Nursing (DON) was present in the facility and was informed by a hall nurse that Resident #1 had a bruise on her left cheek under her eye, redness to her neck and blood on her lips. DON assessed Resident #1 and noted the injuries above. DON began interviewing staff in the facility who stated that previous shift reported the resident was yelling and combative during 3-11 shift while the nurse was attempting to administer her medications. The Administrator and DON began interviewing 3-11 staff from the previous night. Staff reported hearing Resident #1 yelling she hit me. Staff went in to check on the resident upon hearing her yell and did not see anyone hit resident. Licensed Practical Nurse (LPN) #1 stated Resident #1 became combative, yelling and swinging her arms and knocking the medication cup out of the nurse's hand. LPN #1 stated she did not hit or injure the resident. LPN #1 was suspended on 2/21/25 by the Administrator. There were no witnesses present when the incident was believed to have occurred. Upon investigation, the injuries coincide with someone holding the resident's face showing probability that LPN#1 held the resident's mouth to get her to take her medication while she was being combative causing bruising and redness to resident's face and neck. LPN #1 was terminated on 2/24/25. Abuse is substantiated. (continued on next page)

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Record review of Progress Note of LPN #1 dated 2/20/25 at 11:20 PM, revealed, Resident has obvious redness to left side of neck. Resident was combative during med pass this shift swinging her arms and spitting out PO (by mouth) crushed meds with applesauce down face and clothing. CNA (Certified Nursing Assistant) present just outside resident door during this occurrence. Charge nurse (CN) asked to attempt to administer PO crushed meds for second time. CN stated difficulty attempting to administer PO meds. CNA was also present during this medication administration . Record review of Progress Note dated 2/21/25 at 3:14 AM by the DON revealed, At this time, the RN (Registered Nurse) was present in the facility and was informed of redness on (proper name removed) Resident #1's left face and neck. RN was unaware of any prior skin concerns and accompanied the hall LPN to assess the resident. Upon entering the resident's room, the RN observed redness on the left side of the neck and discoloration along the left cheek near the orbital bone. A small amount of dried blood was noted around the resident's mouth, which was cleaned. Upon further assessment, the RN lifted the resident's upper lip and observed bright red blood at the top of the mouth. No active bleeding or additional concerns were noted at this time. RN attempted to wake up resident to inquire about pain or what might of happened, resident lethargic at this time and in no apparent distress or pain. Administrator notified at 0318. Internal investigation began at this point and statements obtained from staff. Resident is on Aspirin and Plavix. Nurse Practitioner notified, no new orders at this time. Representative aware and will be coming to facility at a later time today. Record review of Progress Note dated 2/21/25 at 3:36 AM by hall LPN #1 on night shift revealed, CNAs brought it this nurse attention redness to neck and face and dried blood on resident's mouth and lips. Upon further assessment of resident this nurse noted there to be redness and possible bruising area on left cheek and redness on right cheek. When CNA was cleaning dried blood from mouth there was noted more blood and bloody tissue inside her mouth around gums and teeth, also a raised area on right side of top of tongue. This nurse reported this to Charge Nurse and DON for further assessment. CNA cleaned resident's mouth as best possible until she stated it hurt her mouth. At present time resident is resting in bed with eyes closed and no complaints of pain or discomfort. Record review of a Progress Note dated 2/21/25 at 7:26 AM, by an LPN revealed, Resident complained of mouth pain. Administered PRN (as needed) pain med at this time. Resident has dried blood in corner of left side. Cleaned up with wash cloth and warm water. Monitoring will continue. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	An interview and observation on 3/17/25 at 4:55 PM, revealed Resident #1 lying in bed visiting with her Resident Representative (RR) in the room at her bedside. The resident stated she had been treated with kindness and respect except by one nurse and proceeded to say that nurse brought her medications into her room, and she did not want to take them. The nurse got angry and told her she was going to take them, but the resident refused. She stated the nurse hit her in the face and she grabbed her by her neck and stuck her finger in her mouth and forced it open to give the medication. She stated the nurse Jabbed her finger in my mouth and gums and it hurt for a few days. Resident #1 stated she yelled out and tried to get her to stop. She stated, I just wanted to grab her by the hair and get her away, but I didn't. But I should have so she would know not to do that. She said she could not think of the name of the nurse right now, but she would recognize her. She also said if she did not want her medicine, she should not be forced to take it. She acknowledged she was glad the nurse was fired so she could no longer hurt her or anyone else. The RR said this was the same report and account of the event that the resident had given since the event occurred. The RR asked the resident if it was Licensed Practical Nurse (LPN) #1 (proper name removed) and the resident said Yes, that's her name. The RR did not speak when the resident was giving her statement of the occurrence, and she did not prompt the resident during the interview. The resident was speaking clearly and demonstrated the way the nurse held her neck, mouth, and face and this matched the marks that were left on the resident's face. When away from the resident, the RR said the resident had good days and bad days, but today, she had been very clear with her thought process and her communication. She also stated she was glad that it was such a good day for the resident so she could give her statement of what occurred. During an interview on 3/18/25 at 10:20 AM, the DON stated that she came in to work around 3:00 AM on 2/21/25 due to the charge nurse being sick that day and it was reported to her to look at the resident's face and lips and she and another LPN went in to check on the resident. She stated she noted redness to the left side of the neck and on the left cheek near her eye and dried blood was noted around the mouth. She lifted the resident's upper lip and noted bright red blood at the top of the mouth. She was unable to interview the resident since she was drowsy, but she stated that with the interviews and with the injuries, abuse was suspected, and she notified the Administrator right away and reported this incident and began to get statements and began an investigation. She acknowledged each resident has the right to be free from abuse and neglect and she confirmed the facility failed to ensure this for Resident #1. During an interview by phone on 3/18/25 at 11:30 AM, CNA #1 stated she came into work on 2/20/25 for the 11 PM-7 AM shift and during shift change report she was told that Resident #1 was fighting with LPN #1, and the resident had bruising on her face, neck, and a bloody lip. She stated that inside the resident's mouth on her upper gum area, more active bleeding was noted and the resident said it was hurting. She stated that she reported this to the nurse on her shift. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview by phone on 3/18/25 at 1:00 PM, Charge Nurse/RN #1 stated she was the nurse on 2/20/25 on the 3 PM-11 PM shift when the incident occurred with Resident #1. She stated around 7:00 PM - 8:00 PM, LPN #1 was in Resident #1's room, and she overheard yelling but could not understand what was being said. LPN #1 came out of the resident's room and told her that Resident #1 was fighting with her and would not take her medication. RN# 1 had LPN #1 gather the medications again and she administered the medications to the resident. She then stated that around 10:30 PM - 11:00 PM, that LPN #1 came to her and asked if she would look at the resident's neck and face and she noted some redness, but she thought it was from the resident resting her face on one of her dolls that was in the bed with her. She did not notice any bleeding from her mouth at that time. She stated the next day, the resident had bruising on her face and neck and bleeding in her mouth and complained of pain from her mouth. An interview with Certified Nursing Assistant (CNA) #2 on 3/18/25 at 3:25 PM revealed she was working the 3 PM-11 PM shift on 2/20/25 and she was at the desk charting around 7:30 PM, and she heard Resident #1 screaming and yelled out, You hit me, you hit me. She then saw LPN #1 come out of Resident #1's room and LPN #1 told the Charge Nurse/RN #1 that the resident was fighting her and would not take her medications, and the charge nurse went in to try to give the medications to the resident. When the charge nurse left the resident's room, I went into Resident #1's room and was talking to the resident and noticed her mouth was bleeding and she kept telling me, She hit me, she hit me, she hit me over and over. CNA #3 also came into the room and saw and heard what the resident was saying. CNA #2 stated she did not report this since she thought RN#1 knew because she had just been in the resident's room, but CNA #3 reported this to RN #1 as well. During an interview on 3/18/25 at 3:40 PM, CNA #4 stated she and CNA #3 were working on Resident #1's hall on the 3 PM-11 PM shift on 2/20/25. She stated on the first round there were no concerns noted, but on the second round, CNA #3 told her that Resident #1's mouth was bleeding, so she went to check on her. She noted her mouth was bleeding and she had red marks on the left side of her neck. She asked the resident what happened, and the resident told her the nurse hit her in the face. CNA #4 stated that she then reported this to LPN #1. An interview with CNA #3 on 3/18/25 at 4:20 PM revealed she was working on Resident #1's hall on 2/20/25 for the 3 PM-11 PM shift. She stated that around 7:00 - 8:00 PM, she was performing resident care next door to Resident #1's room, and she heard yelling. She could not understand what was said, but it was Resident #1 and LPN #1 that were in the conversation. She continued to hear the resident crying so as soon as she completed the resident's care, she went into Resident #1's room to check on her and she was still crying, and she noticed her lips were bleeding. She asked the resident what happened and was told that the nurse had hit her in the face. She stated the resident had a bleeding mouth and bruising to her face and neck. She reported this to RN #1, and was told she would check on the resident. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 3/18/25 at 4:30 PM, the Administrator stated this abuse of Resident #1 happened on 2/20/25. He confirmed abuse of a resident occurred in the facility and that they had terminated LPN #1 for abuse of a resident. He further confirmed that with the staff interviews, the resident's validation of the event, and assessment of the injuries that matched the resident's statement, there was enough evidence to validate that LPN #1 was abusive to the resident. He stated they did substantiate the abuse, and they terminated the employee. He stated LPN #1 did not return to work in the facility after the shift when this event occurred. He acknowledged that each resident has the right to be free from abuse and to have their rights honored. He confirmed the facility failed to prevent abuse of a resident. The State Agency had attempted to get in touch with LPN #1 while in the facility on 03/17/25 and 03/18/25 and left a voicemail. LPN #1 contacted the State Agency on 03/21/25 and during a phone interview on 3/21/25 at 8:30 AM, LPN #1 stated she had not worked in the facility since the event occurred and that the facility terminated her. She confirmed that she had been in-serviced on abuse and neglect and stated she worked the 3 PM-11 PM shift on 2/20/25. She stated that she went into the resident's room to give her medication that had been crushed and put in applesauce, but the resident got angry and did not want to take it. She was flailing her arms and knocked the medicine cup out of her hand as she was trying to give the medication with a plastic spoon. She stated she left the room and told RN #1. She stated the resident did not take the medications and she did not place the spoon with the medications in the resident's mouth. She confirmed that, She wouldn't open her mouth, so I didn't put the spoon in there. When asked about her documented progress note and statement revealing the resident spit out the medication, she stated she did not know why her statement and her progress note said that since she did not put anything in the resident's mouth. She confirmed she gave a signed statement of the events that occurred and documented the events that occurred in the progress notes but still claimed she did not put anything in the resident's mouth. Stated she did not know how the injuries happened and that maybe she bit her lip and hit herself with her arms. She once again stated she did not care what she had written in her statement or progress note, she did not give the medicine or put anything in the resident's mouth and that the resident bit her own lip and hit herself. Record review of Resident #1's Injury report revealed, discoloration to left cheek along eye bone, discoloration to left side of neck and dried blood to mouth. Record review of Resident #1's Trauma Informed Care assessment dated [DATE] revealed, Have you ever had anyone grab your throat? That girl grabbed me by throat to try and get me to take my medicine. It's still sore; In the past month, have you: 1. Had nightmares about the event(s) or thought about the event(s) when you did not want to? Yes I have; 2. Tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)? Yes, cause that hurt really bad; 3. Been constantly on guard, watchful, or easily startled? Yes; 4. Felt numb or detached from people, activities, or your surroundings? Yes; 5. Felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused? Yes - I don't feel it was my fault, I blame her. Record review of Personnel Action revealed that the facility terminated LPN #1 on 2/24/25 for suspected abuse of a resident. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Record review of Admission Record revealed the facility admitted Resident #1 on 1/16/24 with diagnoses that included Dementia, Hemiplegia and Hemiparesis following Cerebral Infarction affecting left non-dominant side. Record review of Resident #1's Quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 12/23/24, revealed a Brief Interview for Mental Status (BIMS) score of 7 which indicated severe cognitive impairment.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 41878 Based on observation, resident, resident representative, and staff interviews, record review, and facility policy review, the facility failed to notify the local law enforcement agency and the state Board of Nursing related to abuse of a vulnerable adult for one (1) of seven (7) residents sampled. Resident #1 Findings include: Record review of facility policy titled, Abuse, Neglect, and Exploitation with revision date of 10/10/22, revealed, This facility's policy is to protect each resident's health, welfare, and rights by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. Abuse means the willful infliction of injury . The policy also revealed, The facility will report all alleged violations and all substantiated incidents to the state agency and to all other agencies as required and take all necessary corrective actions depending on the results of the investigation . f. Report to . the nursing board any knowledge of any actions which would indicate an employee is unfit for service . Record review of the Facility Investigation Final Report to the State Agency and Attorney General dated 2/25/25 revealed that on 2/20/25 at approximately 2:30 AM, the Director of Nursing (DON) was present in the facility and was informed by a hall nurse that Resident #1 had a bruise on her left cheek under her eye, redness to her neck and blood on her lips. DON assessed Resident #1 and noted the injuries above. DON began interviewing staff in the facility who stated that previous shift reported the resident was yelling and combative during 3-11 shift while the nurse was attempting to administer her medications. The Administrator and DON began interviewing 3-11 staff from the previous night. Staff reported hearing Resident #1 yelling she hit me. Staff went in to check on the resident upon hearing her yell and did not see anyone hit resident. Licensed Practical Nurse (LPN) #1 stated Resident #1 became combative, yelling and swinging her arms and knocking the medication cup out of the nurse's hand. LPN #1 stated she did not hit or injure the resident. LPN #1 was suspended on 2/21/25 by the Administrator. There were no witnesses present when the incident was believed to have occurred. Upon investigation, the injuries coincide with someone holding the resident's face showing probability that LPN#1 held the resident's mouth to get her to take her medication while she was being combative causing bruising and redness to resident's face and neck. LPN #1 was terminated on 2/24/25. Abuse is substantiated. On 3/17/25 at 4:55 PM, an interview and observation revealed Resident #1 lying in bed visiting with her Resident Representative (RR) in the room at her bedside. The resident stated she had been treated with kindness and respect except by one nurse and proceeded to say that nurse brought her medications into her room and she did not want to take them. The nurse got angry and told her she was going to take them, but the resident refused. She stated the nurse hit her in the face and she grabbed her by her neck and stuck her finger in her mouth and forced it open to give the medication. She stated the nurse Jabbed her finger in my mouth and gums and it hurt for a few days. Resident #1 stated she yelled out and tried to get her to stop. She stated, I just wanted to grab her by the hair and get her away, but I didn't. But I should have so she would know not to do that. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/18/25 at 4:30 PM, an interview the Administrator stated this abuse of Resident #1 happened on 2/20/25 and it was reported to the Attorney General's office and the State Agency. He confirmed he did not notify the local police since he thought it was sufficient to notify the Attorney General's Office which was considered the top law enforcement agency in the state. He also stated this incident with the nurse was not reported to the state Board of Nursing since there were no witnesses to the abuse. He confirmed that the facility had gathered statements from witnesses who overheard the incident, and it correlated with the injuries that the resident sustained. He then confirmed that abuse of a resident did occur in the facility and with the staff interviews, the resident's validation of the event, and assessment of the injuries that matched the resident's statement, there was enough evidence to validate. He stated they did substantiate the abuse, and they terminated the employee. He acknowledged that each resident has the right to be free from abuse and to have their rights honored. He confirmed the facility failed to prevent abuse of a resident and confirmed the facility failed to notify and report this to the local law enforcement agency and to the Board of Nursing after a resident was injured by a nurse. Record review of Admission Record revealed the facility admitted Resident #1 on 1/16/24 with diagnoses that included Dementia, Hemiplegia and Hemiparesis following Cerebral Infarction affecting left non-dominant side. Record review of Resident #1's Quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 12/23/24, revealed a Brief Interview for Mental Status (BIMS) score of 7 which indicated severe cognitive impairment.