

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  255320	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/04/2024
NAME OF PROVIDER OR SUPPLIER  Landmark Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46013</p> <p>Based on observation, staff interview, record review, and facility policy review the facility failed to secure electronic health records as evidenced by an Electronic Medication Administration Record (EMAR) was visible while the medication cart was unattended on the Alzheimer's unit for one (1) of 16 residents residing in the unit. Resident #66</p> <p>Findings Include:</p> <p>Review of the facility policy with a revision date of 11/28/2017 titled Confidentiality of Information revealed, This facility shall maintain an individual's right to privacy and confidentiality of information . Confidentiality of the resident record shall be maintained at all times by keeping the record closed when not in use. If an electronic health record is used, ensure that no other individual can read the screen and log-off the computer when not in use.</p> <p>An observation on 4/2/24 at 10:15 AM, of a computer that was located on a medication cart on the Alzheimer's unit revealed the computer was opened with Resident #66's EMAR information visible on the screen. Licensed Practical Nurse (LPN) #2 was in Resident #66's room and the screen was visible to anyone passing by the medication cart in the hallway. The visible information included Resident #66's name, medications, and room number.</p> <p>An interview on 4/2/24 at 10:18 AM, LPN #2 confirmed that the EMAR for Resident #66 was visible on the screen to anyone walking by and should be closed when she was away from the medication cart to secure private health information. She stated I have to remind myself every day to close the screen before stepping away from the cart. LPN #2 confirmed that this is a violation of keeping the resident's medical records private and a Health Insurance Portability and Accountability Act (HIPAA) issue.</p> <p>An interview on 4/02/24 at 10:50 AM, the Director of Nursing (DON) confirmed that a resident's information should never be left up on the computer screen while the cart is unattended. The DON stated there is a privacy button that is supposed to be pushed before the nurse steps away from the computer. The DON confirmed this is a privacy issue and could result in a HIPAA violation.</p> <p>Record review of Resident #66's Admission Record revealed the resident was admitted to the facility on [DATE] with diagnoses that included Alzheimer's Disease, Anemia, and Atherosclerotic heart disease.</p>

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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<p>F 0623</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45598</b></p> <p>Based on staff interview, record review, and facility policy review, the facility failed to send written notification to the resident and/or resident representative (RR) upon transfer to the hospital for two (2) of two (2) residents reviewed for hospitalization . Resident #30 and Resident #42</p> <p>Findings Include:</p> <p>Review of the facility policy titled Transfer and Discharge with a revision date of 10/18/2022 revealed .Policy Explanation and Compliance Guidelines: . 4. The facility's transfer/discharge notice will be provided to the resident and the resident's representative in a language and manner in which they can understand .</p> <p>Record review of Resident #42's Progress note dated 02/22/24 revealed Resident #42 was found to be non-responsive to verbal or tactile stimuli and her oxygen saturation was 82% 911 was notified for transport to the emergency room (ER) . Resident #42 left the facility by ambulance on 02/22/24 at 6:20 PM.</p> <p>Record review revealed there was not a written notification of transfer given to the family for Resident #42 dated 02/22/24 when she was transferred to the hospital.</p> <p>On 04/02/24 at 12:05 PM, in an interview with Director of Nursing (DON), confirmed that they were not mailing written transfer notifications to the residents' RR's when residents were transferred to the hospital.</p> <p>On 04/02/24 at 1:14 PM, an interview with Social Worker (SW), revealed that she did not have a copy of the transfer/discharge notification dated 02/22/24 on Resident #42, the date she was transferred out to the hospital. The SW revealed that she called the Responsible Party (RP) about bed hold only and confirmed that she had not been mailing the notice of transfer/discharge out to the RP. The SW stated, I didn't realize I was supposed to be mailing them to the RPs, but will get them sent out from now on.</p> <p>Record review of Resident #42's Admission Record revealed that she was admitted on [DATE] and had diagnoses including Chronic Obstructive Pulmonary Disease, Muscle Wasting and Atrophy, and Dementia.</p> <p>Resident #30</p> <p>Record review of the Progress Notes for Resident #30 revealed on 1/12/2024, the resident was transferred to the hospital for .seizure like activity and unresponsive to verbal and physical stimuli .</p> <p>An interview with the SW on 4/02/2024 at 11:20 AM, confirmed she had not mailed out a written notification of transfer/discharge to the RP for Resident #30. She revealed she was unsure who was responsible for doing that.</p> <p>(continued on next page)</p>

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<p>F 0623</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>An interview with the DON on 4/02/2024 at 12:02 PM, revealed that the nurses send out the written notification of transfer/discharge with the residents when they were transferred to the hospital. He confirmed they had not been mailing a copy to the RP.</p> <p>An interview with the Administrator (ADM) on 4/02/2024 at 12:07 PM, revealed he was not aware the written notification of transfer/discharge was not being mailed out to the responsible party's (RP) and confirmed it should have been.</p> <p>Record review of the Admission Record revealed the facility admitted Resident #30 on 12/28/2023 with medical diagnoses which included Seizures and Type 2 diabetes mellitus.</p> <p>47874</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>47874</p> <p>Based on observation, staff interview, record review, and facility policy review, the facility failed to develop a care plan for a resident with a skin concern and Transmission-Based Precautions (TBP) for one (1) of 19 residents sampled. Resident #72</p> <p>Findings Include:</p> <p>Review of the facility policy titled Comprehensive Plan of Care with a revision date of 10/10/2022 revealed Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment .</p> <p>Resident #72</p> <p>Record review of the Order Summary for Resident #72 revealed an order dated 3/31/2024, Contact Isolation due to MRSA (Methicillin Resistant Staphylococcus Aureus) to right hand.</p> <p>Record review of the Order Summary for Resident #72 revealed an order dated 4/03/2024, Clean abrasion to right hand with ns (normal saline), pat dry, cover with small island dressing daily.</p> <p>Record review of Resident #72's Care Plans revealed a care plan was not developed for the skin concern on the right hand that required contact isolation.</p> <p>An interview with Registered Nurse (RN) #1 on 4/03/2024 at 2:10 PM, revealed she was responsible for the development of Resident #72's care plans. She confirmed that she did not develop the care plan related to the skin concern or contact isolation and stated that staff would not know what care to perform.</p> <p>An interview with the Director of Nursing (DON) on 4/03/2024 at 2:50 PM, revealed the purpose of the care plan was for staff to know how to properly care for the resident.</p> <p>Record review revealed the facility admitted Resident #72 on 2/27/2024 with medical diagnoses that included Alzheimer's disease and Major depressive disorder.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>47874</p> <p>Based on observation, staff interview, record review, and facility policy review, the facility failed to use the appropriate Personal Protective Equipment (PPE) while providing care for a resident on contact isolation and failed to dispose of contaminated linens and trash into the designated biohazard containers in the room for one (1) of four (4) residents reviewed for Transmission-Based Precautions (TBP). Resident #72</p> <p>Findings include:</p> <p>Review of the facility policy titled Transmission-Based Precautions with a revision date of 10/10/2022 revealed Policy: It is our policy to take appropriate precautions to prevent the transmission of pathogens based on the pathogens' modes of transmission .Policy Explanation and Compliance Guidelines: . 8. Contact Precautions- . c. Healthcare personnel caring for residents on Contact Precautions wear a gown and gloves for all interactions, that may involve contact with the resident or potentially contaminated areas in the resident's environment. d. Donning personal protective equipment (PPE) upon entry and discarding before exiting the room is done to contain pathogens, especially those that have been implicated in transmission through environmental contamination .</p> <p>Resident #72</p> <p>An observation outside Resident #72's door revealed a sign Contact Precautions -apply gown and gloves. Observed a designated plastic container outside the room door with the required PPE that included gown and gloves. An observation inside the resident's bathroom revealed two (2) biohazard containers designated for linen and trash disposal.</p> <p>Record review of the Culture Miscellaneous with Stain dated 3/27/2024 revealed Methicillin Resistant Staphylococcus Aureus (MRSA) of wound drainage for Resident #72.</p> <p>Record review of the Order Summary for Resident #72 revealed an order dated 3/31/2024, Contact Isolation due to MRSA to right hand.</p> <p>An observation of catheter care for Resident #72, on 4/03/2024 at 9:55 AM, with Certified Nurse Aide (CNA) #1 and #2 revealed, they entered the resident's room and did not apply a gown. CNA #2 performed catheter care with the assist of CNA #1. Following the completion of catheter care, they turned the resident over on his side and changed his brief, repositioned the bed pad and pulled the resident up in the bed. CNA #2 gathered the soiled linen and trash in clear trash bags, exited the room, and threw them into the dirty linen and trash container on 200 hall.</p> <p>An interview with Certified Nurse Aide (CNA) #2 on 4/03/2024 at 10:20 AM, revealed she spoke with the charge nurse on Sunday 3/31/2024 and was told that the resident was contagious, but she did not have to wear a gown. She confirmed that she read the sign outside the resident's door that indicated to wear a gown but did not think anything about it. She stated she knew to place the linen and trash in the biohazard containers in the room but got nervous and messed up. CNA #2 revealed the purpose of separating the linen and trash from other residents was to prevent the spread of infection throughout the facility.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview with the Director of Nursing (DON) on 4/03/2024 at 10:35 AM, revealed for a resident in contact precautions, the staff were expected to dress out in a gown and gloves. He stated the linen and trash were to be discarded in the room to prevent the spread of infection to others in the facility.</p> <p>An interview with the Infection Preventionist (IP) on 4/03/2024 at 10:39 AM, revealed the resident was in contact isolation for MRSA on the right hand. She revealed it was the facility policy to start contact precautions when a culture came back with MRSA. She explained that the staff were expected to wear gowns while providing care. The IP revealed the linen and trash should have been disposed of in the biohazard barrels in the room to prevent the spread of infection.</p> <p>Record review revealed the facility admitted Resident #72 on 2/27/2024 with medical diagnoses that included Alzheimer's disease and Major Depressive disorder.</p>