STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25LI	A. BUILDING: _____ B. WING _____	C 01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND NURSING AND REHABILITATION CENTEI	3680 LAKELAND LANE JACKSON, MS 39216

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M 000	Initial Comments The State Agency (SA) conducted four (4) Complaint Investigations (CI MS #23961, CI MS #23922, CI MS #23923, and CI MS #23924) at the facility, from 1/25/24 through 1/26/24 for Quality of Care/Treatment, Facility Staffing, Resident Rights, and Neglect. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements. M610 was cited related to CI MS #23961 and M500 was cited related to CI MS #23922, and CI MS #23923 and CI MS #23924. The facility remains out of compliance with the Minimum Standards for Institutions for the Aged or Infirm requirements due to a repeat deficiency of M610 from the 12/5/23 survey.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate;	M 500		3/1/24

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M 500	Continued From page 1 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff	M 500		

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M 500	Continued From page 2	M 500		

and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal;

6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law;

7. is free from mental and physical abuse;
8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint;
9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract;

10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;

11. is not required to perform services for the facility that are not included for therapeutic

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M 500	Continued From page 3 purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights.	M 500		

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M 500	Continued From page 4 This Statute is not met as evidenced by: Level II Based on observations, interviews and record reviews the facility failed to ensure call lights were within reach for three (3) of five (5) sampled residents. Resident #3, Resident #4 and Resident #5 Findings Include: Resident #3 On 1/25/24 at 11:15 AM, an observation revealed the call light for Resident #3 was draped over the back of a bedside chair at the end of the resident's bed. The resident was seated on the end of the bed with the call light out of reach. On 1/25/24 at 4:14 PM, an observation revealed the call light for Resident #3 was draped over the back of a bedside chair. The resident was seated in her wheelchair with her call light out of reach. Resident #3 was observed looking for her call light, attempted to reach it, however, the call light was out of reach. On 1/26/24 at 11:18 AM, observation revealed that Resident #3 was seated in her wheelchair in her room with her call light out of her reach, draped over the back of the bedside chair at the end of her bed. She was coughing and sneezing. The resident needed a tissue, but there were none in her room. The resident attempted to reach her call light, but again, her call light was out of reach. On 1/26/24 at 1:50 PM, an interview with Certified Nursing Assistant (CNA) #4 assigned to the care of Resident #3 revealed she stated she had not	M 500	1. Residents #3, 4, and 5 had call light placed within reach by charge nurse on 1.26.24. 2. All residents who require reasonable accommodations have the potential to be affected from alleged this deficient practice. 3. In-service was initiated on 1.26.24 by Staff Development Nurse with nursing staff regarding call lights should be in reach of residents at all times. On 1.29.24 Director of Nursing and Executive Director conducted 100% observation rounds to ensure resident's call lights were within reach. 4. Executive Director and Director of Nursing to conduct room rounds to monitor for compliance. Director of Nursing and Executive Director will audit 10 residents 3 times per week for 2 weeks beginning 1.30.24. Then weekly for 3 weeks to ensure resident call light are within reach of resident. The results of audit will be forwarded to Quality Assurance Committee on 2.20.24 and then monthly for 2 months. 5. Date of completion: 3.1.24	

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M 500	Continued From page 5	M 500		

noticed during morning rounds that the resident's call light was not within her reach. She confirmed that call lights should always be left within reach of the resident.

Record review of the Face Sheet for Resident #3 revealed the resident was admitted by the facility on 4/21/17, with diagnoses that included Spinal Stenosis, Polyosteoarthritis, and Mild Intermittent Asthma, with Status Asthmaticus.

Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) 12/13/23, revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 4, which indicated severe cognitive impairment. Further MDS review revealed Resident #3's used a wheelchair for mobility and was dependent on facility staff for toileting, and personal hygiene, and was always incontinent of bowel and bladder.

Resident #4
On 1/25/24 at 12:15 PM, an observation revealed the call light for Resident #4 was wrapped around the grab bar, wedged between the bar and the mattress hanging down below the mattress on the resident's left side. The bed control was wrapped around the grab bar, wedged between the bar and the mattress hanging down below the mattress on the resident's right side.
Resident #4 stated "I can't find my bed control or call light. I need to be repositioned so I can eat."

Record review of the Face Sheet for Resident #4 revealed the resident was admitted by the facility on 8/22/22, with diagnoses that included Hypertensive Heart Disease with Heart Failure, Morbid Obesity, and Chronic Respiratory Failure with Hypoxia.

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M 500	Continued From page 6 Record review of the Quarterly MDS of Resident #4, with ARD 1/23/24, revealed the resident had a BIMS score of 12, which indicated moderate cognitive impairment. Further review of the MDS revealed that the resident was totally dependent on staff for bed mobility and was always incontinent of bowel and bladder. Resident #5 On 1/25/24 at 12:20 PM, an observation revealed that the call light for Resident #5 was hanging down from the resident's bed dangling just above the floor and not within reach of the resident. Record review of the Face Sheet for Resident #5 revealed the resident was admitted by the facility on 8/18/23, with diagnoses that included Malignant Neoplasm of Unspecified Part of Unspecified Part of Bronchus or Lung, Secondary Neoplasm of the Brain, and Chronic Obstructive Pulmonary Disease. Record review of the MDS for Resident #5, with ARD 11/17/24, revealed the resident had a BIMS score of 14, which indicated Resident #5 was cognitively intact. On 1/26/24 at 3:40 PM, an interview with the Director of Nurses (DON) revealed that she expected all resident's call lights to be positioned within their reach and answered in a timely manner. She confirmed that it was important so that residents could summon assistance as needed.	M 500		
M 610	45.21.2 Activities of daily living Activities of daily living. Each resident shall receive assistance as needed with activities of	M 610		3/1/24

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M 610	Continued From page 7 daily living to maintain the highest practicable well being. These shall include, but not be limited to: 1. Bath, dressing and grooming; 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4. Toileting. This Statute is not met as evidenced by: Level II Based on observation, interview, record review, and facility policy review, the facility failed to ensure that dependent residents received the necessary services to maintain good grooming and personal hygiene for one (1) of five (5) residents reviewed for activities of daily living (ADLs). Resident #1 Findings include: Record review of the facility policy titled, "INCONTINENT CARE," with a review date of 7/12, revealed, "Policy: To provide routine, preventive skin, perineal care to residents after an incontinent episode. Responsibility: All Nursing Personnel ..." Record review of a statement signed by the Executive Director and dated 1/26/24, revealed that the facility did not have a specific policy for ADL (Activities of Daily Living) care. On 1/25/24 at 2:37 PM, an interview with Resident #1 revealed that she received morning care, including incontinent care and a bed bath prior to breakfast on 1/25/24 and received	M 610	1. Resident #1 received assistance with Activities of Daily Living (ADL) by Certified Nursing Assistant on 1.25.24. 2. All resident who receives assistance with Activities of Daily Living (ADL) care regarding incontinence care and transfers have the potential to be affected from this deficient practice. 3. An in-service was initiated on 1.26.24 Staff Development Nurse regarding providing residents assistance with Activities of Daily Living (ADL) and call light response. 4. Director of Nursing and Executive Director to monitor resident #1 for compliance of ADL care. The Director of Nursing and Unit Mangers will audit (5) residents 3 times per week for 3 weeks beginning 1.29.24. Then weekly for 4 weeks to ensure assistance with activities of daily living. The results will be forwarded to monthly Quality Assurance Committee on 2.20.24 and monthly for 2 months.	

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M 610	Continued From page 8 incontinent care following breakfast. She stated that she went to the Therapy Department prior to lunch at approximately 11:45 AM, returned to her room for lunch and then went back to the Therapy Department and finished her therapy. She stated that after she returned to her room after finishing therapy for the day, she was tired, uncomfortable in her wheelchair and her incontinent brief was wet. The resident stated "I turned on my call light and a staff member, I don't know her name, came in and turned off my light and told me that my aide was on break and that she would tell my aide that I needed help when she returned from break." Resident #1 stated that she also reported to the medication nurse that she wanted to get into bed and that she needed to be changed. She stated that she waited almost an hour before her aide came to assist her to transfer to her bed and provide care for her. The resident voiced disappointment that she had to sit in the wheelchair, uncomfortable and with a wet incontinent brief so long. On 1/25/24 at 2:42 PM, an observation revealed Certified Nursing Assistant (CNA) #1 and CNA #2 assisted Resident #1 to transfer from her wheelchair to her bed using a sit-to-stand lift, after which CNA #1 assisted the resident with incontinent care. On 1/26/24 at 3:00 PM, during an interview with the Executive Director revealed she had viewed hallway security camera footage and reported that Resident #1 was returned to her room by a therapist at 1:25 PM. CNA #1 entered the room at 1:30 PM and exited and the resident's call light was engaged at 2:00 PM. She reported that Licensed Practical Nurse (LPN) #1 entered the room at 2:05 PM with the resident's medication and the call light was turned off. She stated that	M 610	5. Date of completion: 3.1.24	

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M 610	Continued From page 9 CNA #1 was observed getting a sit-to-stand lift at 2:30 PM and the resident's call light was engaged again at 2:38 PM. She stated CNA #1 and CNA #2 entered the room at 2:40 PM. The Executive Director confirmed that the resident waited for at least thirty-five (35) minutes for assistance to transfer from her wheelchair to her bed and have assistance for toileting/incontinent care. When asked if Resident #1's wait was an acceptable length of time for the resident to wait, she responded, "It's kind of in between because she requires two-person assistance for transfers and CNA #1 had to wait for CNA #2 to finish care in another room." She confirmed that the resident had not received assistance with toileting or incontinent care since just after breakfast. She denied that the delay was related to lack of staff and that there were other staff available that could have assisted with resident care. Record review of the Face Sheet for Resident #1 revealed that the resident was admitted by the facility on 1/05/24 and with diagnoses that included Essential Hypertension, Type 2 Diabetes Mellitus, Repeated Falls, and Generalized Muscle Weakness. Record review of the 5 Day Minimum Data Set (MDS) with Assessment Reference Date (ARD) 1/12/24 revealed that Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated Resident #1 was cognitively intact. Further MDS review revealed the resident was dependent on facility staff for toileting and was always incontinent of bowel and bladder.	M 610		