STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255116	A. BUILDING _____ B. WING _____	C 01/26/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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 requirements of participation in Medicare and Medicaid. F677 and F656 was cited related to CI MS #23961. F558 and F656 was cited related to CI MS #23922, and CI MS #23923, and CI MS# 23924. The facility remains out of compliance with the requirements of participation in Medicare and Medicaid due to a repeat deficiency of F677 from the 12/5/23 survey. The facility was licensed for 105 beds and had a census of 93 residents at the time of the survey.	F 000		
F 558 SS=E	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: 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	F 558	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	3/1/24

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

Electronically Signed | 02/09/2024

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F 558	Continued From page 1 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 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	F 558	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 light 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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F 558	Continued From page 2	F 558		

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.

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.

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F 558	Continued From page 3 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.	F 558		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive	F 656		3/1/24

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F 656	Continued From page 4 assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, and facility policy review the facility failed	F 656	1. Residents #1,3,4, and 5 were reviewed by the Interdisciplinary Team to ensure	

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F 656	Continued From page 5 to implement interventions included in the individualized care plans for four (4) of five (5) sampled residents. Residents #1, #3, #4 and #5. Findings Include: Record review of the facility policy titled, "COMPREHENSIVE PERSON-CENTERED CARE PLANS," with revision date 3/18, revealed, "Policy: Each resident will have a person centered plan of care to identify problems, needs, strengths, preferences, and goals that will identify how the interdisciplinary team will provide care ... Procedure: ...6. Staff approaches are to be developed for each problem/strength/need ... Assigned disciplines will be identified to carry out the intervention ...." Resident #1 Record review of the Care Plan for Resident #1 with a problem onset date of 1/5/2024 revealed " Total urinary incontinence related to impaired mobility and diuretic med use ...Approaches Toilet checks on me q2h (every 2 hours) and prn ...Keep call light within easy reach of me ... Record review of the Care Plan for Resident #1 with a problem onset date of 1/5/2024 revealed "I require assist with my adl's (activities of daily living) related to incontinence ...Approaches ... Provide my incontinence care q2h and as needed ..." 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	F 656	appropriate interventions are in place and that the care plan is specific to each resident. 2. All residents that require comprehensive person centered care plans have the potential to be affected by this deficient practice. 3. In- service MDS and Nurses on comprehensive care plan by Staff Development Nurse on 1.29.24. 4. Interdisciplinary team conducted a 100% audit of resident care plans to ensure accuracy and individualized beginning 1.29.24. Results of audit reviewed by Executive Director and Director of Nursing weekly for 4 weeks. Then monthly for (2) months. The results of audit will be forwarded to Quality Assurance Committee 2.20.24 then monthly for 2 months. 5. Date of completion: 3.1.24	

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F 656	Continued From page 6	F 656		

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's assessment of functional status revealed the resident was dependent on facility staff for toileting and was always incontinent of bowel and bladder.

On 1/25/24 at 2:37 PM, an interview with Resident #1 revealed that she reported that she was assisted with toileting needs prior to 11:45 AM, she reported that at 1:25 PM upon return to her room from therapy she was tired, uncomfortable in her wheelchair. She stated her incontinent brief was wet and did she not receive toileting assistance until 2:40 PM. Resident #1 confirmed that no staff had assessed her for incontinence care/toileting needs and said she was disappointed at the length of time staff took to respond to her need for assistance with incontinent care/toileting.

Resident #3

Record review of the Care Plan for Resident #3 with a problem onset date of 10/14/2017 revealed "Problem/Need I am at risk for respiratory distress related to my diagnoses of Dyspnea and Asthma ...Approaches: Place my call light within reach ..."

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

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F 656	Continued From page 7	F 656		

Stenosis, Polyosteoarthritis, and Mild Intermittent Asthma, with Status Asthmaticus.

Record review of the Quarterly MDS with an ARD of 12/13/23, revealed the Resident #3 BIMS score of 4, which indicated severe cognitive impairment. Further MDS review revealed Resident #3 used a wheelchair for mobility and was dependent on facility staff for toileting, and personal hygiene, and was always incontinent of bowel and bladder.

On 1/25/24 at 11:15 AM, 1/25/24 at 4:14 PM, and on 1/26/24 at 11:18 AM, observations revealed that Resident #3 was searching for her call light. During each of these times the the call light for Resident #3 was out of her reach.

Resident #4

Record review of the Care Plan with a problem onset date of 8/22/2022 revealed "I am incontinent of bladder ...Approaches ...Keep call light within easy reach of me ..."

Record review of the Care Plan with a problem onset date of 8/22/22 revealed "Problem/Need: I am at risk for Falls due to impaired mobility and antidepressant med use...Approaches...Place my call light and frequently used items within reach ..."

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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F 656	Continued From page 8	F 656		

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.

On 1/25/24 at 12:15 PM, an observation revealed the call light for Resident #4 was out of reach. The resident stated that she could not see or reach her food to feed herself, she needed to be repositioned in bed, but she could not find her bed control or her call light.

Resident #5

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 an ARD of 11/17/24, revealed the resident had a BIMS score of 14, which indicated Resident #5 was cognitively intact.

On 1/25/24 at 12:20 PM, an observation revealed that the call light for Resident #5 was not within reach of the resident.

On 1/26/24 at 3:00 PM, an interview with the Executive Director, she said that she expected all resident's care plans be followed by to for each resident according to the facility Care Plan Policy.

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F 656	Continued From page 9 On 1/26/24 at 3:40 PM, an interview with the Director of Nurses (DON) confirmed that she expected all resident's care plans be followed for each resident according to the facility care plan policy to meet the identified needs of all residents. She confirmed that the Certified Nursing Assistants (CNAs) were provided with instructions for resident care on the computer software program available to all CNAs on the wall mounted kiosks on each hallway. Pocket Care Guides which provide care instructions for each resident based on resident assessment and individualized care plans are also available for the CNAs on how to care for each resident.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: 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	F 677	1. Resident #1 received assistance with Activities of Daily Living (ADL) by Certified Nursing Assistant on 1.25.24. 2. All residents 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.	3/1/24

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F 677	Continued From page 10 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 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	F 677	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. 5. Date of completion: 3.1.24	

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F 677	Continued From page 11	F 677		

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 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255116	A. BUILDING _____ B. WING _____	C 01/26/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 12 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.	F 677		