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 08/13/2021

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

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F 000	INITIAL COMMENTS An Annual Survey and four (4) Complaint Investigations (CI), CI MS #17587, CI MS #17976, CI MS #17971, and CI MS #17967 was conducted by the State Agency (SA) on 8/9/21 through 8/13/21. The facility was found not to be in compliance with infection control regulations of the Centers for Medicare and Medicaid (CMS) and the Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. CI MS #17587, CI MS #17976, and CI MS #17971 was not substantiated. CI MS #17967 was substantiated for Infection Control and the facility was cited F880 when a resident was served a meal that was previously observed by the SA on the tray cart in the Observation and COVID unit. The SA also cited F 561, F563, F 623, F 656, and F 812 during the Annual Survey. The census was 74 and the facility has a license for 105 beds.	F 000		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying,	F 880		10/6/21

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

Electronically Signed | 09/16/2021

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F 880	Continued From page 1	F 880		

reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the

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F 880	Continued From page 2 corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record reviews, and facility policy review, the facility failed to prevent the possible spread of infection for one (1) of three (3) meals observed. Resident #34. Findings Include: A record review of the facility's policy, "Standard Precautions", reviewed date 1/15, revealed, "POLICY: Standard Precautions will be utilized to provide a primary strategy for the prevention of healthcare-associated infectious (HAI) agents among patients and healthcare personnel". A review of the facility's policy, "Contact Precautions", dated 9/19, revealed, "POLICY: Contact Precautions are a transmission based precaution that will be utilized to reduce the risk of epidemiologically important micro-organisms by direct or indirect contact". On 8/11/21 at 12:26 PM during an observation and interview with Resident #34 revealed he had not been served a lunch tray although Resident #34's roommate had been served a meal tray. Resident # 34's roommate confirmed the meal	F 880	1. Food is being served in a matter to prevent the possible spread of infection. Resident #34 had no ill affects from food tray that was served. CNA # 3 was inserviced regarding meal service on the unit with meal trays passed to each resident prior to the meal cart going into the Covid unit for meal service which at that time the meal tray cart and meal trays/boxes are considered contaminated and cannot be returned to the regular unit for usage. CNA # 3 had disciplinary action filed in her personnel file 8/11/21. 2. All residents that receive a food tray have the potential to be affected. 3. The Infection Preventionist in-serviced nurses and certified nurse aides beginning 8/11/21 regarding infection control and meal service on the unit with meal trays passed to each resident prior to the meal cart going into the Covid unit for meal service which at that time the meal tray cart and meal trays/boxes are considered contaminated and cannot be returned to the regular unit for usage.	

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F 880	Continued From page 3 tray, which was observed on his bedside table, was his lunch tray. Resident # 34 stated they (staff) had not brought his lunch tray yet. On 8/11/21 at 12:31 PM, the SA exited Resident #34's room the SA looked through the window of the closed double doors onto the Observation Unit and observed CNA #3 near the meal tray cart and noted there were meal trays still on the cart. The SA observed CNA #3 push the meal tray cart back into the 100 Hall and removed a tray and took it into Resident # 34's room. The SA observed CNA #3 place the tray on the bedside table. The SA asked the CNA #3 to take the tray out of Resident # 34's room. CNA #3 took the tray out of the room and placed on meal tray cart. On 8/11/21 at 12:34 PM in an interview with CNA #3, she stated she forgot to take Resident #34's tray off the meal tray cart before taking the meal tray cart into the Observation and COVID-19 units. On 8/11/21 at 2:15 PM in an interview with LPN #2, the facility's Infection Preventionist (IP), she stated that everything on the meal cart should have been disposed of and Resident #34 should not have gotten the tray because it can cause cross contamination, from the COVID-19 area to the clean area and the resident could have gotten COVID-19. On 8/13/21 at 9:07 AM, in an interview with CNA #3, she stated she was told if the tray was covered it was okay to give it to the resident. She stated the Observation and COVID-19 Units are contaminated and Resident #34 could get sick. On 8/13/21 at 9:13 AM, in an interview with LPN	F 880	Meal tray cart must be sanitized with Vindicator prior to leaving the Covid Unit. An in-service was initiated on 9/21/21 by an external registered nurse related to infection control and meal service on the unit with meal tray/boxes passed to each resident on that unit prior to the meal cart going into the Covid unit for meal service which at that time the meal tray cart and meal trays/boxes are considered contaminated and cannot be returned to the regular unit for usage. Meal tray carts are sanitized with Vindicator before removed from the Covid unit. All nurses and certified nurse assistants will not be able to work until inserviced. 4. The Infection Preventionist and/or Unit Nurse Managers will make observation rounds starting 8/16/21 to ensure that anything that goes on the Covid unit will be disinfected before leaving the Covid unit five times weekly times two weeks, four times weekly times two weeks, three times weekly times two weeks, two times weekly times two weeks and weekly thereafter. The Infection Preventionist will forward the infection control observation audits results to the Executive Director weekly starting 8/23/21 and weekly thereafter. The Executive Director will forward the infection control observation audit results of Infection Control Observation rounds to the Quality Assurance committee monthly beginning 9/16/21. The Quality Assurance committee make recommendations and changes to the plan if indicated.	

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F 880	Continued From page 4	F 880		

#3, she stated the residents back there (indicating the Observation and COVID-19 Units) are COVID-19 positive and under observation. She further acknowledged CNA #3 had exposed Resident #34 to COVID-19 by taking the meal tray into his room. She stated it could cause the resident to become ill and there is a chance Resident #34 could die from COVID-19 if he were to get it. She further stated CNA #3 is agency staff.

On 8/13/21 at 9:17 AM, in an interview with Interim Director of Nursing (DON), she stated CNA #3 should not have passed out meal trays the way she did and CNA #3 should have served Resident #34 his meal tray before she took the meal tray cart into the Observation and COVID-19 Units. She acknowledged the resident was put at risk for possible infection and CNA #3 should have called dietary and gotten another tray for the resident.

On 8/13/21 at 10:15 AM, in an interview with LPN #4/Staff Development/Human Resources, she stated when Agency staff come to the facility to get their work schedule, the facility completes an abbreviated orientation package. The package, which contains information on Infection Control, must be completed by agency staff before the facility will allow them to work. She also confirmed the residents on the Observation Unit are treated as if they are positive for COVID-19 and she should have gotten another tray for the resident because it had been exposed to COVID-19.

On 8/13/21 at 10:27 AM, in an interview with LPN #2/ Infection Preventionist, she stated CNA #3 should have thrown the meal tray away and

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F 880	Continued From page 5	F 880		

gotten another meal tray because the tray had previously been in a contaminated area. She acknowledged the Observation Unit is a contaminated area. LPN #2 further explained before CNA's bring the meal tray rack back from the contaminated side, they are supposed to spray it down with Vindicator, which is a disinfectant. She stated if CNA #3 had sprayed the cart down with Vindicator with a meal tray on the rack, then Resident #34's meal tray would have been sprayed with a disinfectant. She further explained if his meal tray was sprayed with a disinfectant prior to his eating the meal, it can cause the resident to have pain in the abdomen, nausea and vomiting and if the resident is allergic to Vindicator, it can cause anaphylactic shock. LPN #2 admitted Resident #34 had a chance of getting COVID-19 because COVID-19 lives on a surface for up to 72 hours. She stated she had conducted an in-service for the staff and educated them that anything that goes through the doors to the Observation and COVID-19 Units is contaminated. She stated anything that comes back through the contaminated area and into the hallway needs to be cleaned with Vindicator and placed in a water soluble bag or in a biohazard bag.

On 8/13/21 at 12:08 PM, in an interview with LPN #4/ Staff Development/ Human Resources, she stated CNA #3 had not completed the orientation package. and CNA #3 advised her she did not complete the package. She stated CNA #3 started working at the facility on 8/1/21.

On 8/13/21 at 12:45 PM, in an interview with LPN #4, she stated CNA #3 was in-serviced on 8/5/21 on Biohazard and Infection Control.

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F 880	Continued From page 6 Record review of the Educational Inservice Record dated 8/5/21, revealed, the title of the inservice was Medical Waste/Biohazard - Trash and Linens, and the topic was Regulated Medical Waste. CNA #3 signed the record as having attended the inservice. A review of Resident #34's initial Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 8/16/21, Section C revealed a Brief Interview for Mental Status (BIMS) score of 12 which indicates he is cognitively intact.	F 880		