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 05/22/2024

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 The State Agency (SA) conducted a Complaint Investigation (CI), MS #25028, CI MS #24916, CI MS #24971, CI MS #24816 and CI MS #24480 at the facility from 5/19/24 through 5/22/24. CI MS #25028, CI MS #24916, and CI MS #24971 were investigated regarding the same incident involving an allegation of employee to resident abuse. CI MS #24816 was investigated regarding quality of care related to call lights, services not provided, staffing, incontinent care, and Administration. CI MS#24480 was investigated regarding quality of care related to staffing and dietary services. During the survey, the SA determined that the facility was not in compliance with the requirements for participation in Medicare and Medicaid and cited F550 related to CI MS #25028, CI MS #24916, and CI MS #24971. Although the SA did not determine the allegations rose to the level of abuse, it was determined that the residents were not treated with dignity and respect. The facility held a license for 105 beds, with a census of 90.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that	F 550		7/1/24

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

Electronically Signed | 06/11/2024

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F 550	Continued From page 1 promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on staff and Resident Representative (RR) interviews, record review, facility investigation, and policy review the facility failed to ensure nursing staff treated residents with respect and dignity during procedures and medication administration for two (2) of eight (8) residents sampled. Residents #5 and Resident #6.	F 550	1. Resident #5 was interviewed by Executive Director on 5/23/2024 regarding allegation of using demanding and disrespectful behavior. Resident #6 was interviewed by Executive Director on 5/23/24 regarding complaint of rude behavior from cart nurse. Licensed Practical Nurse was assigned to another	

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F 550	Continued From page 2 Findings Include: Record review of the facility's policy titled, "Resident Bill of Rights," reviewed/revised on 1/23, revealed, "Each resident has a right to a dignified existence... and communication with and access to persons and services inside and outside the facility in a manner and in an environment that promotes maintenance or enhancement of (his or her) quality of life...10. Reside and receive services in the facility with reasonable accommodation or resident needs and preferences ..." Resident #5 During an interview with Resident #5 on 5/19/24 at 1:22 PM, she stated Licensed Practical Nurse (LPN) #1 was "disrespectful and demanding" when she entered her room to collect a urine sample. She explained that this conduct was nothing new. This nurse had frequently treated her in this manner. She stated that, despite her desire to avoid interaction with the nurse because she becomes "uneasy" around her, she just followed all of the instructions given to her during the process. She pointed out the facility is only now transferring her meds to another nurse, despite her repeated complaints that the current nurse is disrespectful. She added that even though another nurse administered her medications, LPN#1 still worked on her hall, which made her nervous to see her. Resident #5 shared her wishes not to see the nurse at all. Record review of a handwritten statement written by LPN #1 dated 4/24/24 revealed " ...Asked resident how she cleaned herself and she stated	F 550	unit and not assigned these residents to ensure residents do not have contact with this nurse. Resident #5 and resident #6 had no ill effects from the alleged deficient practice. 2. All residents on the North Unit had a potential to be affected by the deficient practice. 3. Licensed Practical Nurse#1 was provided directed one-on-one in-service regarding customer service and resident rights to include dignity and respect on 5/22/24 by Director of Nursing. LPN received competency 5/22/24 regarding medication administration and urine sample collection by Staff Development Coordinator. LPN#1 was re-assigned to another unit in the facility effective 5.22.24. An in-service was conducted on 5.23.24 with all staff regarding resident's rights, dignity, respect and customer service by Staff Development Coordinator. 4. All residents will be monitored for any issues and complaints 3 times per week for 4 weeks, then weekly for 2 weeks beginning on 5/23/24 by Social Services Director and/or Executive Director. LPN#1 will be monitored by Director of Nursing to ensure appropriate performance of duties 3 times per week for 4 weeks, then weekly for 2 weeks beginning 5/27/24. LPN #1 will have performance review monthly for 2 months. First review 6.21.24 and then 7.19.24.The results of audits will be forwarded to Quality Assurance committee for 2 months beginning 6/14/24	

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F 550	Continued From page 3 after I get through, I wipe myself ...Noted with a lot of nasty toilet paper between her legs, in her vaginal area ... Informed resident this is probably why you're hurting because this tissue is nasty ..." Record review of the police department "Voluntary Statement "dated 4/24/24 revealed, " ...She spread me wide and started wiping hard and it was hurting ...I was afraid she was going to do me bodily harm. Her body language and tone of voice said so. The hold time she was digging and stretching, I was yelling "Stop You're hurting me. She would not stop ..." Record review of the "Supervisor Investigation Summary Form" dated 04/24/2024 at 8:45 AM, revealed facility's investigation revealed Resident #5 made an allegation of employee-to-resident abuse that occurred on 4/19/24. The facility's findings revealed that the allegations of abuse were not valid and that the resident was reassigned to another unit related to the resident "not liking" the Licensed Practical Nurse (LPN). In an interview with the RR on 5/20/24 at 9:48 AM, she disclosed that she had previously informed the Director of Nursing (DON) and Administrator on numerous occasions that her mother had reported LPN#1 was ""unkind and disrespectful to her. Nevertheless, she asserts that they would defend the nurse, suggesting that the situation is not as severe as her mother portrayed it. In the absence of any evidence, she was unable to take any action. However, in the present scenario involving the urine sample, she insisted that the nurse stop administering her mother's medications. Subsequently, they transferred her medications to another nurse. She noted that the Administrator offered her	F 550	and 7.10.24. The Quality Assurance Committee will determine the frequency or discontinuation of audits based upon results achieved.	

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F 550	Continued From page 4	F 550		

mother a relocation to a different area of the facility, but she declined. However, she believes the nurse should have relocated to a different hall. She also stated from what she gathers, her mother experiences anxiety upon encountering the nurse and tries to avoid her.

During an interview with LPN #1 on 5/20/24 at 10:53 AM, she verified that she was the nurse responsible for entering Resident #5's room to collect a urine sample. She also disclosed that she typically works the night shift in the north corridor, which is where Resident #5 is located. Furthermore, she frequently picks up extra shifts in the central hall. She clarified that the medications for Resident #5 were transferred to another nurse due to her knowledge that the resident harbors animosity toward her and makes up stories about her. She also mentioned that there are other residents who lie and disapprove of her because she refuses to let them have their way.

In an interview with the Unit Manager (LPN#2) for north hall on 5/21/24 at 10:13 AM, she confirmed that Resident #5 did express concerns about LPN#1 before this current complaint. However, she would have to check her notes to remember the actual concerns.

On 5/21/24 at 10:25 AM, during the interview with the DON, she said there is just a personality conflict between LPN#1 and the resident because she is a by-the-book nurse. She says Resident #5 tends to want to take multiple medications at one time, and LPN #1 tells her she cannot give them all at one time. She points out that LPN #1 is very tall and has a deep voice, so her presence and tone can come across as harsh. She thinks

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Resident #5 is accusing the nurse of being rude because of the nurse's outward appearance, tone, and pitch.

A record review of the "Face Sheet" of Resident #5 revealed the facility admitted the resident on 5/12/17. Her diagnoses included Urinary Tract Infection, Paranoid Schizophrenia, and Generalized Anxiety Disorder.

A record review of Resident #5's annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 4/24/24 revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact.

Resident #6

On 5/20/24 at 10:35 AM, during an interview with Resident #6, she stated she reported to the Administrator about LPN #1's rudeness a few months ago, and the nurse's behavior improved. Nevertheless, LPN#1 has recently resumed her previous behavior of being "demanding and rude" when administering medication or performing any medical procedures with her. The resident admits that she experiences anxiety when in the presence of LPN#1 and responds to her inquiries without hesitation, merely responding with "yes" or "no" as required. She continued by stating that she had asked the Unit Manager (LPN #2) to prevent LPN #1 from returning to her room. Still, LPN#1 continues to administer her medications. The resident asserted that she should not be required to experience feelings of anxiety or nervousness in the presence of any staff members. She stated "this facility is my home and the employees should be mindful of the manner in which they interact with all the

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residents."

On 5/20/24 at 11:05 AM, during the interview with the RR of Resident #6, she revealed that in recent visits with the resident, she was told LPN #1 had started "being mean and demanding" again, over the last couple of weeks or so. She indicated that she could tell the nurse makes her aunt anxious, and the facility should have fired the nurse or moved her off the hall when Resident #6 had made the first complaint regarding LPN #1, back in March.

On 5/22/24 at 10:48 AM, the Administrator confirmed that she was aware Resident #6 had complained about LPN #1 and addressed the allegation immediately. She acknowledged she counseled LPN#1 but did not move Resident #6's medication to another nurse or move LPN#1 to another hall. The Administrator added that as of 5/22/24, LPN #1 was moved to another hall.

A record review of the "Face Sheet" revealed the facility admitted Resident #6 on 1/11/24. Her diagnoses included Depression and Urinary Tract Infection.

A record review of the Quarterly MDS, for Resident #6, with an ARD of 4/12/24, revealed a BIMS of 15, which indicated the resident was cognitively intact.