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	255338	A. BUILDING _____ B. WING _____	06/27/2024

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LAMAR HEALTHCARE & REHABILITATION CENTER	6428 US HIGHWAY 11 LUMBERTON, MS 39455

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an Annual Recertification Survey and Complaint Investigations (CI MS #25290 and CI MS #25624), at the facility from 6/24/24 through 6/27/24. CI MS #25290 was investigated related to a resident left wet and F550 and F656 were cited. CI MS #25624 was investigated related to abuse and there were no citations related to the complaint. During the recertification survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F565, F679, F804, F868 and F883. The facility had a census of 67 with a bed capacity of 120.	F 000		
F 550 SS=G	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 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	F 550		7/23/24

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

Electronically Signed | 07/17/2024

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F 550	Continued From page 1 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: MS CI #25290 Based on observation, staff and resident interviews, record review, and facility policy review, the facility failed to ensure residents dignity, physical, mental or psychosocial needs were met as evidenced by residents not receiving assistance with incontinence care in a reasonable timeframe for two (2) of 17 sampled residents. (Resident #8 and Resident #34) Findings include: Review of the facility's policy, "Routine Resident Checks" revised July 2013, revealed "Staff shall make routine resident checks to help maintain	F 550	This Plan of Correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. 1. Root cause was completed by the Quality Assurance and Performance Committee (QAPI) on 07-12-2024. Based on findings the certified nursing assistant #1 and #2 of resident # 8 and resident # 34 failed to provide timely incontinent care	

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F 550	Continued From page 2 resident safety and well-being. Policy Interpretation and Implementation ...2. Routine resident checks involve entering the resident's room ...identify whether the resident has any concerns, and see if the resident ...needs toileting or assistance ..." Review of the facility's policy, "Residents rights" revised February 2021, revealed, "Employees shall treat all residents with kindness, respect, and dignity. Policy Interpretation and Implementation 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence b. be treated with respect, kindness, and dignity ..." Record review of the facility policy "Dignity" revised February 2021 revealed " ...Policy Interpretation and Implementation ...5 ....e. provided with a dignified dining experience ..." Resident #8 During an observation and interview on 06/24/24 at 10:24 AM, Resident #8 was lying in bed and there was a strong odor of urine and feces. She was alert and oriented and stated she had informed Certified Nursing Assistant (CNA) #1 earlier in the morning that she had an accident with urine and a bowel movement (BM). CNA #1 told her she would be back, but she had not returned. Resident #8 explained she had to be transferred with a Hoyer lift (a type of mechanical lift) and it required two (2) staff members to provide care, therefore, she normally received care once during a shift. On 06/24/24 at 12:15 PM, during an observation,	F 550	of resident #8 and resident # 34 which resulted in each residents eating their lunch meal in their rooms in soiled adult briefs. Registered nurse supervisor and director of nurses assessed resident #8 and resident #34 at 4:00pm on 6-24-2024 and it was found that incontinent care had been completed for resident #8 and resident #34 by certified nursing assistant #1 and #2. Resident #8 and resident #34 were each clean and dry at this time. 2. All residents have the potential to be affected by this practice. 3. Education was initiated on 06-24-2024 by director of nurses for certified nursing assistants #1 and #2 verbally regarding incontinence care of residents. The clinical staff was educated by Director of nurses by in-service and skills lab with a check off sheet on 7-14-2024 regarding proper perineal care for clinical staff members. These interventions will be completed by 7-22-2024. Director of nurses also made staffing changes of certified nursing assistant #1 and #2 in July of 2024. 4. Director of nurses (DON) will conduct a quality review of timely incontinence care each week on five extensive assistance residents starting 06-28-2024 and continuing for 60 days. The findings of the quality reviews by DON will be reported in the QAPI Committee meeting on 7-23-24 and will bring to monthly QAPI x2 months.	

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CNA #2 took a lunch meal tray into Resident #8's room.

On 06/24/24 at 12:20 PM, Resident #8 explained that she still had not been changed. She was tearful and stated that she did not care for eating lunch with urine and feces on her because it was humiliating.

On 06/24/24 at 12:45 PM, during an observation, CNA #2 removed Resident #8's lunch meal tray from her room. Resident #8 asked the CNA if they were going to clean her up and she responded that she would be back.

On 06/24/24 at 1:00 PM, during an observation, both CNAs assigned to Resident #8 were on a lunch break.

During an observation and interview on 06/24/24 at 2:00 PM, with Resident #8, she revealed she had not received incontinence care all day. The room continued to have a strong foul odor.

On 06/24/24 at 2:05 PM, during an interview and observation, Resident #8 was lying in bed with a heavily soiled brief, in which feces were spilling over the top and sides of the brief. Resident #8 stated, "This is what I deal with every day." She stated that she was soiled "most of the time" and she depended on staff for assistance to get her out of bed. Resident #8 became tearful and stated she felt degraded and "nasty". She reiterated that she did not want to eat her meals while wearing a brief that was soiled.

During an observation on 06/24/24 at 2:08 PM, CNA #1 and CNA #2 were providing incontinence care to Resident #8. Her brief and bedding were

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saturated with urine and feces.

During an interview on 06/24/24 at 2:25 PM with CNA #1 and CNA #2, CNA #1 stated she was assigned to Resident #8 and had checked on her earlier this morning and she was clean with no urine or feces at that time. Both CNAs said they had to do rounds together for all the other residents on the hall and was unable to check on Resident #8 until now. CNA #2 confirmed that she gave the resident her lunch tray and picked it up. Both CNAs explained they are not allowed to clean a resident up during lunch time because they were told that it was an issue with cross contamination, and therefore, residents had to eat their meals when they were wet and soiled.

In an interview on 06/24/24 at 3:00 PM, with Registered Nurse (RN) #1, she explained the CNAs should check on the residents every two (2) hours and that residents should not have to eat meals while lying in feces and urine. The nurse confirmed the staff does not clean the residents up during meals to prevent cross contamination, but CNAs should check on the resident's before meals and provide care at that time.

During an interview on 06/25/24 at 11:00 AM, with the Director of Nursing (DON), she explained the CNAs should check on the residents every two (2) hours and confirmed Resident #8 should have been cleaned up before lunch. The DON confirmed the staff was trained to not provide care during meals to prevent cross contamination.

A record review of the "Face Sheet" revealed the facility admitted Resident #8 on 3/5/10 with

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current diagnoses including Hemiplegia.

A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/19/24 revealed Resident #8 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated she was cognitively intact. Further review revealed she was dependent on staff for toileting hygiene.

Resident #34

During an observation 06/24/24 at 11:00 AM, Resident #34's family member informed RN #3 that the resident had urinated and needed assistance.

During an observation on 06/24/24 at 12:31 PM, revealed Resident #34 was lying in bed eating her lunch and the staff had not provided incontinence care that was requested at 11:00 AM, which was prior to lunch.

On 06/24/24 at 2:34 PM, during an observation with RN #3, Resident #34 continued to wear a heavily saturated brief.

During an interview on 06/24/24 at 3:36 PM, with RN #3, she confirmed Resident #34's brief was saturated with urine. RN #3 said she had reported to CNA #1 and Licensed Practical Nurse (LPN) #1 that the family member had requested for the resident to be cleaned at 11:00 AM. RN #3 also confirmed she did not check back to ensure the staff had provided the requested care.

During an interview on 06/24/24 at 3:39 PM, with LPN #1, she stated the CNAs informed her the resident had said she did not want to be bothered

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F 550	Continued From page 6 at that time and she did not follow up with the resident. She said she expected the CNAs to go back later and see if the resident had changed her mind. During an interview on 06/26/24 at 11:42 AM, with the DON, she stated the CNAs should have reported the resident's refusal to the nurse when she first refused, and they should have followed up to see if the resident had changed her mind. During an interview on 06/27/24 at 12:28 PM, with the Administrator, she stated she expected the staff to provide care when the resident needs it, and the residents should be treated with dignity and respect. A record review of the "Face Sheet" revealed the facility admitted Resident #34 on 6/29/18 with current diagnoses including Alzheimer's Disease. A record review of the Quarterly MDS with an ARD of 5/17/24 revealed Resident #34 had a BIMS score of 3, which indicated her cognition was severely impaired. Section GG revealed she required maximum assistance with toileting hygiene.	F 550		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend	F 565		7/23/24

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F 565	Continued From page 7 resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and resident council minutes review, the facility failed to resolve resident repeated concerns of cold food served to the residents rooms for three (3) of six (6) months reviewed. January 2024, April 2024, and May 2024. Findings Include: Observation and interview on 06/25/24 1:00 PM with the Resident Council revealed 12 residents	F 565	1. Root cause was identified and discussed during Quality Assurance and Performance Improvement (QAPI) Committee on 07-12-2024. Facility failed to resolve complaint that some meals were not served at a proper temperature to residents' rooms. 2. All residents who receive meal trays in their room have the potential to be affected by this practice.	

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F 565	Continued From page 8 attended the meeting. Residents were comfortable and multiple residents vocalized concerns with the temperature of food served in their rooms. Residents denied issues with food temperatures served in dining room. Resident #70 stated the food temperature of eggs and other food delivered to his room are cold. Resident #54 confirmed his food was cold as well. Other residents stated this is an ongoing issue with cold food. Resident #54 stated the council had complained to staff multiple times for several months about the food without improvement. Review of the monthly grievance log minutes revealed complaints related to the temperature of their food for the following months: Jan 2024 April 2024 May 2024 Review of January 2024 minutes revealed, "Food that comes to rooms still seems to be inconsistent in temperature. Majority (residents) say it is cold." The May 7, 2024 minutes revealed residents suggested "heated carts" for food transport to rooms. There was no evidence of attempts by the facility to resolve the grievance. Observation and interview 06/25/24 2:10 PM of the kitchen revealed single runner stacked open metal carts with a clear plastic cover. The Dietary Manager (DM) confirmed these carts are used to deliver food to the halls. The DM said the trays are served according to hall, starting with 100, 200, 300, then 400 halls. The DM stated she was aware the facility residents have complained about food temperatures. She explained temperatures are checked on the food holding	F 565	3. In-service education was started on 7-02-2024 by dietary manager and director of nurses to all dietary staff and clinical staff on the units regarding proper food temperature when trays are served to residents in their rooms. In-service education was also started on 7-02-24 by director of nurses to all clinical staff regarding the handing out of trays as soon as dietary staff brings tray carts to each unit to ensure that food will be served at an acceptable temperature for those residents choosing to eat in their rooms. Steam deck has been ordered on 7-16-2024 and will be replaced in dietary upon its arrival. 4. Dietary manager will begin review of logs weekly starting 06-28-2024 and any deviance from acceptable food temperatures will be reported to dietary manager, administrator, and maintenance. These deviances will also be brought before Quality Assurance and Performance Improvement Committee for monitoring on July 22, 2024 and times three months.	

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F 565	Continued From page 9 table in the kitchen prior to plating the food. Interview on 06/25/24 2:50 PM with the facility Administrator revealed the facility is "monitoring" and "talking to residents" and are aware of the cold food concerns. The Administrator stated she had talked to the DM about serving trays to 100 hall then 300 hall, then 200 and 400 shorter halls. The Administrator went on to say that CMS (Centers for Medicare and Medicaid Services) did not pay the facility enough to buy insulated or heated carts for delivery of food to the halls. She stated she would have to start back at square one to address the cold food complaints.	F 565		
F 656 SS=G	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 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	F 656		7/23/24

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F 656	Continued From page 10 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 observation, staff interviews, record review, and facility policy review, the facility failed to implement comprehensive care plan interventions regarding incontinence care for two (2) of 17 care plans reviewed. (Resident #8 and Resident #34) Findings Include: Record review of the facility's policy, "Care Plans, Comprehensive Person Centered" revised March 2022, revealed, "A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the	F 656	1. Root cause was completed by the Quality Assurance and Performance Committee (QAPI) on 07-12-2024. Based on findings facility failed to implement comprehensive care plan interventions in a timely manner for incontinence care of resident #8 and resident # 34. 2. All residents have the potential to be affected by this practice. 3. Education was initiated on 06-24-2024 by director of nurses (DON) verbally with certified nursing assistants #1 and #2	

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F 656	Continued From page 11 resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation ...3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. ...7. The comprehensive, person-centered care plan ...b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being ..." Resident #8 Record review of the "Self-Care Deficit" care plan with a start date of 4/1/24 for Resident #8 revealed " ...Resident is ...total/depended with assist of 2 with hoyer lift ...Ext/Max (extensive/maximum) assist with ... toileting...Intervention Assist with ADL's (Activities of Daily Living) as needed ..." The role listed as "Nursing Assistant". On 06/24/24 at 10:24 AM, Resident #8 was lying in bed and there was a strong odor of urine and feces. She was alert and oriented and stated she had informed Certified Nursing Assistant (CNA) #1 earlier in the morning that she had an accident with urine and a bowel movement (BM). CNA #1 told her she would be back, but she had not returned. Resident #8 explained she had to be transferred with a Hoyer lift (a type of mechanical lift) and it required two (2) staff members to provide care, therefore, she normally received care once during a shift. On 06/24/24 at 2:00 PM, during an observation and interview, Resident #8 stated she had not	F 656	regarding implementation of comprehensive care plan for incontinence care. DON provided in-service on timely incontinence care by implementing comprehensive care plan interventions and skills lab with check off list regarding proper perineal care on 07-14-2024. These interventions will be completed by 7-23-2024. A kardex system will also be implemented by 7/23/2024 on each unit so clinical staff can see important information quickly regarding care of each resident on that unit. 4. Director of nurses will conduct a quality review of timely incontinence care each week on five extensive assistance residents starting 6/28/2024 and continue for 60 days. The findings of the quality reviews will be brought in the monthly QAPI Committee meeting starting 7/22/24 x3 months.	

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F 656	Continued From page 12	F 656		

received incontinence care all day. The room continued to have a strong, foul odor.

On 06/24/24 at 2:08 PM, during an observation, CNA #1 and CNA #2 were providing incontinence care to Resident #8. Her brief and bedding were saturated with urine and feces.

During an interview on 06/24/24 at 2:25 PM with CNA #1 and CNA #2, both CNAs said they had to do rounds together for all the other residents on the hall and were unable to check on Resident #8 until now.

During an interview on 06/25/24 at 11:00 AM, the Director of Nursing (DON) confirmed the CNAs failed to follow the comprehensive care plan by not providing incontinence care when it was needed. The DON said the CNAs should have checked on the residents every two (2) hours and she should have been cleaned before lunch.

A record review of the "Face Sheet" revealed the facility admitted Resident #8 on 3/5/10 with current diagnoses including Hemiplegia.

A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/19/24 revealed Resident #8 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated she was cognitively intact. Section GG revealed she was dependent on staff for toileting hygiene.

Resident #34

Record review of the "Urinary Incontinence and bladder incontinence" care plan with a start date of 4/1/24 for Resident #34 revealed ...

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F 656	Continued From page 13 Intervention ... Assist with perineal cleansing as needed ... On 06/24/24 at 11:00 AM, during an observation, Resident #34's family member informed Registered Nurse (RN) #3 the resident had urinated and needed assistance. During an observation with RN #3 on 06/24/24 at 2:34 PM, Resident #34 continued to wear a heavily saturated brief. During an interview on 06/26/24 at 11:42 AM, the DON confirmed the staff failed to implement the care plan intervention to provide perineal care as needed. During an interview on 06/27/24 at 10:52 AM, RN #3 explained the care plan was used to guide the resident's care. She expected the staff to follow the care plan by providing incontinence and perineal care as needed by the residents in a timely manner. A record review of the "Face Sheet" revealed the facility admitted Resident #34 on 6/29/18 with current diagnoses including Alzheimer's Disease. A record review of the Quarterly MDS with an ARD of 5/17/24 revealed Resident #34 had a BIMS score of 3, which indicated her cognition was severely impaired. Section GG revealed she required maximum assistance with toileting hygiene.	F 656		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities.	F 679		7/23/24

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F 679	Continued From page 14 §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews, and record review, the facility failed to provide one on one (1:1) activities for residents on isolation in the COVID-19 unit for one (1) of six (6) residents (Resident #32), with the potential to affect all residents on the unit. Findings Include: Review of the facility's policy, "Activity Programs" revised June 2018, revealed, "Activity programs are designed to meet the interest of and support the physical, mental and psychosocial well-being of each resident. Policy Interpretation and Implementation ...2. Activities offered are based on the comprehensive resident-centered assessment and the preferences of each resident. 3. The activities program is ongoing and includes ...independent individual activities ...12. Individualized and group activities are provided that ...c. reflect the ...personal preferences of the residents ..." During an observation and interview on 06/24/24 at 12:00 PM, Resident #32 was in her room on the COVID-19 unit. She stated she liked to watch television (TV) but enjoyed hunting or auto	F 679	1. Root Cause Analysis was completed by the Quality Assurance and Performance Improvement (QAPI) Committee on 07-12-2024. Based on findings the facility failed to provide one on one activities for resident #32 on isolation precautions due to COVID-19 active diagnosis. Resident #32. Isolation precautions were discontinued on 6-29-2024 for resident #32 and was moved back to her regular room. 2. All residents who were on isolation precautions have the potential to be affected by this practice. 3. In-service education was completed by Director of Nurses on 07-02-2024 with Activities Director and all clinical staff regarding any resident who is on isolation precautions to have one on one activities initiated by Activities Director or a member of the clinical team within twenty-four hours of isolation precautions being ordered and one on one activity will take place at least daily until resident has had isolation precautions discontinued. All one	

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F 679	Continued From page 15 channels because it reminded her of her husband. She was unable to change the TV channel by herself. During an observation 6/25/24 at 13:25 PM, Resident #32 was in her room, but the TV program was not on a hunting or auto channel of her preference. She stated that since she had been in the unit, no one had asked her what she liked to do or had conducted any activities with her. During an interview on 06/26/24 at 9:00 AM, the Activities Director (AD) stated she had been in her position for a few months and had been assessing residents to determine their interests. Resident #32 had not been assessed yet to determine her interests and preferences. She explained Resident #32 had been receiving 1:1 activities and she had documented it on the participation record, however she was unable to produce a copy of the resident's participation record. On 6/27/24 at 10:00 AM, Certified Nurse Aide (CNA) #3 explained that she worked five (5) days a week, 12-hour days, Monday through Friday, on the COVID-19 unit. She was the only CNA that worked the unit on the day shift. She stated she had not observed any in-room activities for the residents on the unit and has not seen anyone from Activities on the unit. A record review of the "Face Sheet" revealed the facility admitted Resident #32 on 5/31/18 and she had current diagnoses of Type 2 Diabetes Mellitus. A record review of the Quarterly Minimum Data	F 679	on one activities will be charted into each resident's medical record. There was not any charting done for resident #32 because isolation precautions were discontinued on 6-29-2024 and resident #32 was moved back to regular room. 4. Once a resident has been placed on isolation facility will begin daily one on one activity for the entire duration of isolation. Results will be taken to the next Quality Assurance Performance Improvement Meeting after isolation precautions have been discontinued.	

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F 679	Continued From page 16 Set (MDS) with an Assessment Reference Date (ARD) of 5/23/24 revealed Resident #32 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated she was cognitively intact. Review of Section F revealed it was very important for Resident #32 to do her favorite activities.	F 679		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews, record reviews and facility policy reviews, the facility failed to ensure that residents received food in a manner that was palatable and at a temperature that was satisfactory, for one (1) of 17 sampled residents. Resident #70 Findings include: A review of the facility policy titled, "Meal Service," (undated), revealed, "Policy... Food will be delivered promptly to ensure safe, palatable and high-quality food served at the appropriate temperature...Procedure: ... 6. Food will be served at palatable temperatures as discerned by customary practices...."	F 804	1. Root cause was identified and discussed during Quality Assurance and Performance Improvement (QAPI) Committee on 07-12-2024. Facility failed to resolve complaint by resident #70 that some meals were not served at a proper temperature in residents' rooms. 2. All residents who receive meal trays in their room have the potential to be affected by this practice. 3. In-service education was started on 7-02-2024 by dietary manager and director of nurses to all dietary staff and clinical staff on the units regarding proper food temperature when trays are served	7/23/24

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F 804	Continued From page 17 On 6/24/24 at 10:11 AM, during an interview with Resident #70, the resident stated everything is fine with the facility, except the food. The resident stated that he prefers to eat in his room, however, he complained that all of the meals that have been brought to his room have been cold. The resident added that he has been at the facility for three (3) weeks. During a Resident Council Meeting that was held on 6/25/24 at 1:00 PM, Resident #70 was in attendance. While the residents were discussing their complaints regarding the temperature of the meals served in their rooms, Resident #70 stated that the eggs and other food items brought to his room were cold. Other residents mentioned that there has been a persistent problem with cold meals. The residents in the Council meeting added that there has been no improvement in food temperatures noted, despite their complaints for several months about cold food. In an interview with the Administrator on 6/25/24 at 2:50 PM, she stated that CMS (Centers for Medicare and Medicaid Services) had not given the facility enough money to purchase insulated carts for food delivery to the hallways. On 6/26/24, during a follow-up interview with Resident #70, he complained that his food remains cold. The resident added that he is only able to consume around three-fourths (3/4) of his meals and he is only able to do that because he is hungry. He stated that is the food was "hot," he would eat it all. A record review the "Face Sheet," for Resident #70 reveals the facility admitted the resident on 5/10/2024. The resident's diagnoses included	F 804	to residents in their rooms. In-service education was also started on 7-02-24 by director of nurses to all clinical staff regarding the handing out of trays as soon as dietary staff brings tray carts to each unit to ensure that food will be served at an acceptable temperature for those residents choosing to eat in their rooms. Steam deck has been ordered on 7-16-2024 and will be replaced in dietary upon its arrival. 4. Dietary manager will begin review of logs weekly starting 06-28-2024 and continue for 60 days. These reviews will be brought before Quality Assurance and Performance Improvement Committee on July 22, 2024 for discussion and continue x2 months.	

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F 804	Continued From page 18 Essential (Primary) Hypertension and Hyperlipidemia. A record review of the Minimum Data Set (MDS), for Resident #70, with Assessment Reference Date (ARD) of 6/7/24, revealed a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment.	F 804		
F 868 SS=F	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are	F 868		7/23/24

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F 868	Continued From page 19 necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review and facility policy review, the facility failed ensure that the Infection Preventionist was present in the QAPI (Quality Assurance and Performance Improvement) Committee for 12 of the 12 months of meetings reviewed. July 2023 through June 2024. This had the potential to affect the quality of healthcare for all residents residing in the facility. Findings include: A review of the facility's policy titled, "Quality Assurance and Performance Improvement (QAPI) Program-Governance and Leadership," revised March 2020, revealed, "...The Quality Assurance and Performance Improvement Program is overseen and implemented by the QAPI Committee...The following individuals serve on the committee: a. Administrator, or designee who is in a leadership role; b. Director of Nursing Services; c. Medical Director; d. Infection Preventionist...The committee meets at least quarterly (or more often as necessary) ..." Record review of the facility's QAPI Committee meeting sign in logs for the 12 meetings held from July 2023 through June 2024,	F 868	1. Root Cause Analysis (RCA) was completed by the Quality Assurance and Performance Improvement (QAPI) Committee on 07/12/2024 and it was determined the facility failed to have the facility Infection Preventionist (IP) present at each monthly Quality Assurance and Performance Improvement Committee meeting. 2. All residents have the potential to be affected by this practice. 3. In service education was initiated on 07/02/2024 by the Director of Nurses (DON) to the infection preventionist regarding attendance to each monthly QAPI meeting. 4. Administrator will audit attendance record for each QAPI Committee Meeting starting 07-23-2024 times three months.	

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F 868	Continued From page 20 documentation revealed the Infection Preventionist was not present for any of the 12 meetings. On 6/27/24 at 12:30 PM, during an interview with the Administrator, she acknowledged the facility's QAPI committee meets monthly, but did not have the Infection Preventionist present at all the meetings. The Administrator stated the importance of the IP being present is to improve the quality of healthcare for the residents. She stated that going forward, she will expect that the IP be present at the QAPI meetings.	F 868		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and	F 883		7/23/24

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F 883	Continued From page 21 (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record reviews, and facility policy review the facility failed to ensure residents were offered Influenza and Pneumonia vaccinations as evidenced by no documentation indicating vaccinations were either offered or administered to residents who were eligible for eight (8) of the 17 sampled residents. Residents	F 883	1. Root cause analysis was completed by the Quality Assurance and Performance Improvement (QAPI) Committee on 7-12-2024. It was determined that the facility failed to ensure residents # 6, # 12, # 13, # 29, # 38, and # 39 were offered or administered influenza and pneumonia	

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F 883	Continued From page 22 #6, #12, #13, #29, #38, #39, #48 and #70 Findings include: Review of the facility's policy titled, "Influenza Vaccine," revised 8/16, revealed, " ... residents admitted between October 1st and March 31st shall be offered the vaccine within five (5) working days of ... the resident's admission to the facility ..." Review of the facility's policy titled," Pneumococcal Vaccine," revised 8/16, revealed, " ...Prior to or upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccine series and when indicated, will be offered the vaccine series within thirty (30) days of admission to the facility unless medically contraindicated or the resident has already been vaccinated ..." A record review of the medical records for Residents #6, #12, #13, #29, #38, #39, and #48 revealed no documentation these residents received the Influenza Vaccine in 2023. There was no documentation the vaccine was offered and the residents declined. A record review of the medical records of Residents #38, #39, #48, and #70 revealed there was no documentation of the residents previously receiving the Pneumonia Vaccine or offered by the facility and declined. According to medical record reviews, Residents #6, #12, #13, #29, #38, #39, and #48 should have been offered the 2023 Influenza Vaccine and Residents #38, #39, #48, and #70 should have been offered the Pneumonia Vaccine.	F 883	vaccinations within thirty days of admission to facility starting 06-28-2024 for eligible residents. This will be an on-going process in the facility for new admissions. Residents were found to not have correct documentation on each resident's chart stating that they consent to each vaccination or refuse vaccinations. 2. All residents have the potential to be affected by this practice. 3. Director of nurses met with newly appointed infection preventionist for in service education on 07-02-2024. All new admissions will have a vaccination packet completed and appropriate vaccines given within thirty days of admission of each resident by infection preventionist and placed on that resident's chart. All current residents will have a consent or refusal for influenza and pneumonia vaccinations on their medical record by 07-23-2024. 4. Medical records staff will monitor all new admission's x3 months to ensure correct documentation is in place starting on 06-28-2024. Any deviations from this plan of correction will be brought before QAPI beginning 7/22/24 x3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255338	A. BUILDING _____ B. WING _____	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAMAR HEALTHCARE & REHABILITATION CENTER	6428 US HIGHWAY 11 LUMBERTON, MS 39455

(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 883	Continued From page 23 On 06/27/24 at 11:54 AM, in an interview with Registered Nurse (RN) #1/Infection Preventionist (IP), she stated when a resident is admitted to the facility, she checks their medical records for vaccine history. She stated if she cannot locate the information, she will ask the resident or family for information regarding recent immunization. If the resident has not had the recent Influenza Vaccine, or has not had the Pneumonia Vaccine, if it is appropriate for the resident to receive the vaccines, she is supposed to offer the vaccine(s) to the resident. However, she confirmed that she had not followed up and offered the vaccinations to many of the residents. The IP acknowledged that the vaccine should have been offered, as it decreases the residents' chance of getting the Flu and Pneumonia. Record review of the "Face Sheets" revealed admission dates for Resident #6 as 10/12/15, Resident #12 as 9/4/20, Resident #13 as 2/28/24, Resident #29 as 10/24/19, Resident #38 as 4/2/19, Resident #39 as 1/26/22, Resident #48 as 3/20/24, and Resident #70 as 5/10/24.	F 883		