MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37LH	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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M 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 F656 and F690 were cited. CI MS #25624 was investigated related to abuse and there were no citations related to the complaint. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirement and cited M475, M500, M585, M620, M780 and M865.	M 000		
M 475	45.16.6 Employee Testing for Tuberculosis Employee Testing for Tuberculosis 1. Each employee, upon employment of a licensed entity and prior to contact with any patient/resident, shall be evaluated for tuberculosis by one of the following methods: a. IGRA (blood test) and an evaluation of the individual for signs and symptoms of tuberculosis by medical personnel; or b. A two-step Mantoux tuberculin skin test administered and read by a licensed medical/nursing person certified in the techniques of tuberculin testing and an evaluation of the individual for signs and symptoms of tuberculosis by a licensed Physician, Physician ' s Assistant, Nurse Practitioner or a Registered Nurse. 2. The IGRA/Mantoux testing and the evaluation of signs/symptoms may be administered/conducted on the date of hire or administered/read no more than 30 days prior to	M 475		7/23/24

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M 475	Continued From page 1 the individual ' s date of hire; however, the individual must not be allowed contact with a patient or work in areas of the facility where patients have access until receipt of the results of the IGRA/assessment or at least the first of the two-step Mantoux test has been administered,/read and assessment for signs and symptoms completed. 3. If the Mantoux test is administered, results must be documented in millimeters. Documentation of the IGRA/TB skin test results and assessment must be documented in accordance with accepted standards of medical/nursing practice and must be placed in the individual ' s personnel file no later than 7 days of the individual ' s date of employment. If an IGRA is performed, results and quanitive values must be documented. 4. Any employee noted to have a newly positive IGRA, a newly positive Mantoux skin test or signs/symptoms indicative of tuberculin disease (TB) that last longer than three weeks (regardless of the size of the skin test or results of the IGRA), shall have a chest x-ray interpreted by a board certified Radiologist and be evaluated for active tuberculosis by a licensed physician within 72 hours. The employee shall not be allowed to work in any area where residents have routine access until evaluated by a physician/nurse practitioner/physician assistant and approved to return. Exceptions to this requirement may be made if the employee is asymptomatic and; a. The individual is currently receiving or can provide documentation of having received a course of tuberculosis prophylactic therapy approved by the Mississippi State Department of	M 475		

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M 475	Continued From page 2 Health (MSDH) Tuberculosis Program for tuberculosis infection, or b. The individual is currently receiving or can provide documentation of having received a course of multi-drug chemotherapy approved by the MSDH Tuberculosis Program; or c. The individual has a documented previous significant tuberculin skin reaction or IGRA reaction. 4. For individuals noted to have a previous positive to either Mantoux testing or the IGRA, annual re-evaluation for the signs and symptoms must be conducted and must be maintained as part of the employee ' s annual health screening. A follow-up annual chest x-ray is NOT required unless symptoms of active tuberculosis develop. 5. If using the Mantoux method, employees with a negative tuberculin skin test and a negative symptom assessment shall have the second step of the two-step Mantoux tuberculin skin test performed and documented in the employees ' personal record within fourteen (14) days of employment. 6. The IGRA or the two-step protocol is to be used for each employee who has not been previously skin tested and/or for whom a negative test cannot be documented within the past 12 months. If the employer has documentation that the employee has had a negative TB skin test within the past 12 months, a single test performed thirty (30) days prior to employment or immediately upon hire will fulfill the two-step requirements. As above, the employee shall not have contact with residents or be allowed to work	M 475		

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M 475	Continued From page 3 in areas of the facility to which residents have routine access prior to reading the skin test, completing a signs and symptoms assessment and documenting the results and findings. 7. All staff noted as negative per the IGRA blood test or who do not have a significant Mantoux tuberculin skin test reaction (reaction of less than 5 millimeters in size) shall be retested annually within thirty (30) days of the anniversary of their last IGRA or Mantoux tuberculin skin test. Staff exposed to an active infectious case of tuberculosis between annual tuberculin skin tests shall be treated as contacts and be managed appropriately. Individuals found to have a significant Mantoux tuberculin skin test reaction and a chest x-ray not suggestive of active tuberculosis, shall be evaluated by a physician or nurse practitioner/physician assistant for treatment of latent tuberculin infection. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure annual Tuberculosis (TB) screens were conducted for 86 of 106 employees. Findings include: A review of the facility's policy, "Employee Testing for Tuberculosis", undated revealed " ...annually, a signs and symptoms sheet will be filled out by the employee to satisfy the state TB guidance." On 06/27/24 at 9:00 AM, a record review of the "TB Assessment and/or Follow-up for Staff and Residents" forms revealed 86 of 106 staff forms were older than 12 months. On 06/27/24 at 9:17 AM, during an interview with Registered Nurse (RN) #1, she acknowledged the	M 475	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 Analysis was completed by the Quality Assurance and Performance Improvement Committee (QAPI) on 07-12-2024. Based on findings the facility was not in compliance with employee Tuberculosis assessments being completed in May of 2024.	

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M 475	Continued From page 4 employee TB screenings were more than a year old. She was unsure who was responsible for ensuring the employee signs and symptoms (s/s) screens were performed yearly. RN # 1 reported it was very important for all employees to have TB s/s screens yearly. On 06/27/24 at 9:45 AM, an interview with the Director of Nursing (DON) revealed the employee TB assessments had been completed over a year ago. She stated it was the responsibility of RN #2 to complete the employee screens and the facility had not gotten to them yet. They had planned to update them next week. She stated it was her expectation for TB s/s screens to be completely yearly. On 06/27/24 at 10:54 AM, in an interview with the Administrator, she stated it was her expectation that the employee TB s/s be completed annually.	M 475	2. All employees have the potential to be affected by this practice. 3. Tuberculosis signs and symptoms assessment sheet has been completed by Director of Nursing on each employee starting 6/29/24 and will be completed by 07-23-2024. In-service was completed by Director of Nurses to all staff on 07/02/2024 in regards to each employee having a tuberculosis signs and symptoms assessment completed in May of each year by designated nurse. 4. Administrator will ensure that Director of Nurses completes a tuberculosis signs and symptoms assessment on each employee by 07-23-2024. All new hires will fill out tuberculosis signs and symptoms assessment for during facility orientation starting 7-02-2024. This will be done by staff development nurse during facility orientation. Director of nurses will monitor this process starting 7-02-2024 and continue for 90 days and audit will be brought to monthly QAPI meeting starting 7/22/24 and continue x3 months.	
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's	M 500		7/23/24

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M 500	Continued From page 5 responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record;	M 500		

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M 500	Continued From page 6 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to	M 500		

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M 500	Continued From page 7 another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room,	M 500		

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M 500	Continued From page 8 unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level III 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 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,	M 500	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 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	

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M 500	Continued From page 9 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, 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	M 500	perineal care for clinical staff members. These interventions will be completed by 7-23-2024. 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 06/28/24 x 60 days. The findings of the quality reviews by DON will be reported in the monthly QAPI Committee meeting beginning 7-22-24 x2 months.	

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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 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

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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 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,

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M 500	Continued From page 12 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 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,	M 500		

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M 500	Continued From page 13 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.	M 500		
M 585	45.20.2 Tuberculosis (TB) Tuberculosis (TB). Admission Requirements to Rule Out Active Tuberculosis (TB) 1. The following are to be performed and documented within 30 days prior to the resident ' s admission to the " Licensed facility " : a. TB signs and symptoms assessment by a licensed Physician, Physician ' s Assistant or a Licensed Nurse Practitioner, and b. A chest x-ray taken and a written interpretation. 2. Admission to the facility shall be based on the results of the required tests as follows: a. Residents with an abnormal chest x-ray and/or signs and symptoms assessment shall have the first step of a two-step Mantoux tuberculin skin test (TST) placed and read by certified personnel OR an IGRA (blood test) drawn and results documented within 30 days prior to the patient ' s admission to the " Licensed facility " . Evaluation	M 585		7/23/24

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M 585	Continued From page 14 for active TB shall be at the recommendation of the MSDH and shall be prior to admission. If TB is ruled out and the first step of the TST is negative, the second step of the two-step TST shall be completed and documented within 10-21 days of admission. TST administration and reading shall be done by certified personnel. If an IGRA (blood test) is done, TST (first and/or second step) is not done. b. Residents with a normal chest x-ray and no signs or symptoms of TB shall have a baseline IGRA test (blood test) OR a TST performed with the initial step of a the two-step Mantoux TST placed on or within 30 days prior to the day of admission. IF TST is done, the second step shall be completed within 10-21 days of the first step. TST administration and reading shall be done by certified personnel. If an IGRA (blood test) is done, a TST is not done (first or second step). c. Residents with a significant TST OR positive IGRA (blood test) upon baseline testing or who have documented prior significant TST shall be monitored regularly for signs and symptoms of active TB (cough, sputum production, chest pain, fever, weight loss, or night sweats, especially if the symptoms have lasted longer than three weeks) and if these symptoms develop, shall have an evaluation for TB per the recommendations of the MSDH within 72 hours. d. Residents with a non significant TST or negative IGRA (blood test) upon baseline testing shall have an annual tuberculosis testing within thirty (30) days of the anniversary of their last test. Note: Once IGRA testing is used, IGRA testing should continue to be used rather than TST testing.	M 585		

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M 585	Continued From page 15 e. Residents with a new significant TST or newly positive IGRA (blood test) on annual testing shall be evaluated for active TB by a nurse practitioner or physician or physician ' s assistant. f. Active or suspected Active TB Admission. If a resident has or is suspected to have active TB, prior written approval for admission to the facility is required from the MSDH TB State Medical Consultant. g. Exceptions to TST/ IGRA requirement may be made if: i. Resident has prior documentation of a significant TST/ positive IGRA. ii. Resident has received or is receiving a MSDH approved treatment regimen for latent TB infection or for active TB disease. iii. Resident is excluded by a licensed physician or nurse practitioner/physician assistant due to medical contraindications. This Statute is not met as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to administer Tuberculosis (TB) skin test annually for one (1) of 17 sampled residents. (Resident #17) Findings include: A review of the facility's "Tuberculosis Policy", undated, revealed, "...annually, the resident will have a TB signs and symptoms form fill out and a TB skin test given and read." A record review of the "Face Sheet" revealed the	M 585	1. Root cause was identified by the Quality Assurance and Performance Committee (QAPI) on 7-12-2024. It was determined that the facility was not in compliance with annual tuberculosis policy in regards to residents. Tuberculosis sign and symptoms sheet has been filled out on each resident that was not in compliance and a tuberculosis skin test has been administered and read by the director of nurses for those that were not in compliance. Director of nurses placed tuberculosis skin test on each resident in	

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M 585	Continued From page 16 facility admitted Resident #72 on 03/10/20 with current diagnoses including Dementia. On 6/27/24 at 9:05 AM, a record review of an immunization sheet provided by the facility revealed Resident #72's last TB skin test was administered on 05/23/23, which was more than one year ago. On 06/27/24 at 09:17 AM, an interview with Registered Nurse (RN) # 1, she acknowledged Resident #72's TB skin was administered more than a year ago. She reported she was unsure who was responsible for administering the TB tests and ensuring they were up to date. She stated it was important for residents to have TB skin tests annually as required. On 06/27/24 at 09:45 AM, an interview with the Director of Nurses, she acknowledged Resident #72's TB skin test was administered over a year ago. She stated it was RN #1's responsibility to administer TB skin tests. The DON explained the facility had not gotten to all the residents to administer the TB tests, but going forward she would make sure all residents received TB skin tests every year. On 06/27/24 at 10:54 AM, an interview with the Administrator revealed it was the responsibility of RN #1 and the nursing department to keep the TB skin tests up to date. Her expectation was for all residents to receive the TB skin tests timely.	M 585	the facility on 07-07-2024 and each tuberculosis skin test was read by director of nurses on 07-10-2024. 2. All residents have the potential to be affected by this practice. 3. In-service education was started on 07-02-2024 by director of nurses to educate staff that each resident will have a tuberculosis sign and symptom assessment sheet along with a tuberculosis skin test placed and read by director of nurses and/or infection preventionist in May of each year for facility to be in compliance. All current residents are up to date and compliant with tuberculosis sign and symptoms assessment sheet performed by director of nurses on 07-7-2024. All current residents will have a tuberculosis skin test placed and read by director of nurses by 07-10-2024. 4. Director of nurses will conducted a review on 7-10-2024 to ensure that all residents are compliant with tuberculosis sign and symptoms assessment sheet completion and that each resident is compliant with tuberculosis skin test being placed and read by director of nurses and/or infection preventionist. The month of May is designated to be the month all annual tuberculosis signs and symptoms assessment sheet and skin test will be placed and read by infection preventionist for each resident. All findings from review done by director of nurses on 7-10-2024 will be discussed in monthly QAPI committee meeting beginning 7/22/24 x3	

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M 585	Continued From page 17	M 585	months.	
M 620	45.21.4 Urinary incontinence Urinary incontinence. Residents with urinary incontinence shall be assessed for need of bladder retraining program. An indwelling catheter will not be used unless the resident ' s clinical condition indicates that catheterization is necessary. These residents shall receive treatment and services to prevent urinary tract infections. This Statute is not met as evidenced by: Level III 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 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 ..."	M 620	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 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	7/23/24

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M 620	Continued From page 18 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, 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	M 620	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 7-23-2024. 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 07-02-2024 and continue for 60 days. The findings of the quality reviews by DON will be reported in the monthly QAPI Committee meeting starting on 7/22/24 and continuing for x3 months.	

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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 not able to attend the facility's activities because 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 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

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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 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

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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 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

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M 620	Continued From page 22 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.	M 620		
M 780	45.27.2 Activity Program Activity Program. Provisions shall be made for suitable recreational and entertainment activities for resident according to their needs and interests. These activities are an important adjunct to daily living and are to encourage restoration to self-care and resumption of normal activities. Variety in planning shall include some outdoor activities in suitable weather. This Statute is not met as evidenced by: Level II 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.	M 780	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	7/23/24

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M 780	Continued From page 23 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 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	M 780	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 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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	37LH	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) COMPLETE DATE
M 780	Continued From page 24 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 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.	M 780		
M 865	45.30.9 Serving of Meals Serving of Meals. 1. Table should be of a type to seat not more than four (4) or six (6) residents. Residents who are not able to go to the dining room shall be provided sturdy tables (not TV trays) of proper heights. For those who are bedfast or infirm tray service shall be provided in their rooms with the tray resting on a firm support.	M 865		7/23/24

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M 865	Continued From page 25 2. Personnel eating meals or snacks on the premises shall be provided facilities separate from and outside of food preparation, tray service, and dishwashing areas. 3. Foods shall be attractively and neatly served. All foods shall be served at proper temperature. Effective equipment shall be provided and procedures established to maintain food at proper temperature during serving. 4. All trays, tables, utensils and supplies such as china, glassware, flatware, linens and paper placemats, or tray covers used for meal service shall be appropriate, sufficient in quantity and in compliance with the applicable sanitation standard. 5. Food Service personnel. A competent person shall be designated by the administrator to be responsible for the total food service of the home. Sufficient staff shall be employed to meet the established standards of food service. Provisions should be made for adequate supervision and training of the employees. This Statute is not met as evidenced by: Level II 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,"	M 865	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.	

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M 865	Continued From page 26 (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...." 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	M 865	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. These reviews will be brought before Quality Assurance and Performance Improvement Committee beginning 7/22/24 x3 months.	

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M 865	Continued From page 27 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 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.	M 865		