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	255338	A. BUILDING _____ B. WING _____	C 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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F 550	Continued From page 5	F 550		

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 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	F 656		7/23/24

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F 656	Continued From page 7 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 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	F 656	1. Root cause was completed by the	

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F 656	Continued From page 8 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 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	F 656	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 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 9	F 656		

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 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.

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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 ... 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

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F 656	Continued From page 11 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		