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 _____	C 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

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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 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 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	M 500		7/23/24

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M 500	Continued From page 1 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; 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;	M 500		

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M 500	Continued From page 2 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 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	M 500		

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M 500	Continued From page 3 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, 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	M 500	1. Root cause was completed by the Quality Assurance and Performance Committee (QAPI) on 07-12-2024. Based	

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M 500	Continued From page 4 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, 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	M 500	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 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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M 500	Continued From page 5 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 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	M 500		

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M 500	Continued From page 6	M 500		

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 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.

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M 500	Continued From page 7 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, 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	M 500		

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M 500	Continued From page 8 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, 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		

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M 620	Continued From page 9	M 620		
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 ..." Review of the facility's policy, "Residents rights" revised February 2021, revealed, "Employees	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 incontinence care of residents. The clinical staff was educated by Director of nurses by in-service and skills lab with a check off	7/23/24

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M 620	Continued From page 10 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 humiliating. On 06/24/24 at 12:45 PM, during an observation,	M 620	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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M 620	Continued From page 11	M 620		

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 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

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M 620	Continued From page 12	M 620		

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 staff for toileting hygiene.

Resident #34

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 _____	C 06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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M 620	Continued From page 13 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 up to see if the resident had changed her mind. During an interview on 06/27/24 at 12:28 PM, with	M 620		

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M 620	Continued From page 14 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		