STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255116	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND NURSING AND REHABILITATION CENTER LLC	3680 LAKELAND LANE , JACKSON, Mississippi, 39216

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS On 9/02/25 through 9/03/25 the State Agency (SA) conducted Complaint Investigations (CI) at the facility for CI MS #475480, CI MS# 2568468 and CI MS# 2583490. CI MS #475480 was investigated related to nursing services, quality of care/treatment and physical environment. CI MS # 2583490 was investigated related to nursing services, quality of care related to call lights function and timely response and physical environment. There were no deficiencies cited for these CIs. CI MS # 2568468 was investigated related to physician services, neglect and resident rights/discharge rights. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid related to and F550 was cited related to CI MS 2568468. At the time of the survey, the facility had a census of 90 and is licensed for 105 beds.	F0000		
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of	F0550		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0550 SS = D	Continued from page 1 payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on record review, facility policy review and interviews, the facility failed to ensure resident discharge rights by not providing all medications, specifically as needed pain medications, for one (1) of four (4) discharged residents. Resident #1. Findings include: Record review of the facility policy “Discharge Medications” with the most recent history of July 2024 revealed “Procedure: 1. Medications are sent with the resident on discharge based on…the physician’s order…” On 9/03/25 at 3:40 PM, during an interview Licensed Practical Nurse (LPN) #1 confirmed she had been working on 6/27/25 when Resident #1 discharged home with home health care. She stated she didn’t recall reviewing upcoming scheduled appointments with the resident prior to discharge. She confirmed she used the Current Medications list included in the Transfer/Discharge Reported dated 6/27/25 to review medications with the resident and that the list included a current prescription for Hydrocodone-Acetaminophen Oral Tablet 5-325 MG (milligrams) one (1) tablet by mouth every 6 hours as needed for pain. LPN #1 stated she did not send the resident’s Hydrocodone-Acetaminophen tablets home with her because “I was told if it was a certain number.” She could not explain. She stated that she recalled discussing pain medications with other nurses but had not consulted the prescribing physician or the	F0550		

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F0550 SS = D	Continued from page 2 resident's primary healthcare provider for clarification. On 9/03/25 at 4:07 PM, during an interview the Minimum Data Set (MDS) Nurse stated that she had participated in discharge planning for Resident #1. She stated that discharge planning began upon admission. She stated that Resident #1 had been her own Representative and made her own healthcare decisions. She confirmed that Resident #1 had decided to discharge a few days early and had personally made her decision known to her primary healthcare provider (PHP) in person during an in person visit to the facility. She stated she had arranged home health care for Resident #1 prior to discharge from the facility. She stated that it was not unusual for residents to be instructed to follow-up with their PHP for refills, but that current medications should be sent home with the resident unless otherwise instructed by the physician. On 9/03/25 at 4:13 PM, during an interview with the Director of Nursing (DON) revealed residents were to be discharged with all current medications unless otherwise instructed by the resident's physician. She stated that Resident #1 had undergone hip replacement surgery approximately two weeks prior to discharge from the facility and had other pain related diagnoses and that she had been admitted with. Resident #1 had physician orders for Hydrocodone-Acetaminophen Oral Tablet 5-325 MG (1) tablet by mouth every 6 hours as needed for pain. She confirmed that the order was still current at the time of the resident's discharge from the facility and the PHP had not issued any explicit instructions or orders that the medication be discontinued. She confirmed that Resident #1 had telephoned the facility the week following discharge and complained that her Hydrocodone-Acetaminophen Oral Tablet 5-325 MG had not been sent home with her. On 9/03/25 at 4:25 PM, during an interview the Administrator stated that it was the policy of the facility that unless otherwise instructed/ordered by the PHP all medications were to be discharged with the resident following discharge conference with the resident and/or their representative during which all medications were to be discussed as well as notification of scheduled appointments. Record review of the "Admission Record" for Resident #1 revealed the facility admitted the resident on 6/13/25 with diagnoses that included Aftercare following joint replacement surgery and End stage renal disease. Record review of the 5-Day MDS with an Assessment	F0550		

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F0550 SS = D	Continued from page 3 Reference Date (ARD) 6/20/25 revealed the resident had a Brief interview for Mental Status score of 10, which indicated moderate cognitive impairment. Section J indicated Resident #1 received PRN (as needed) pain medications and frequently had pain that interfered with sleep and limited day-to-day activities and had recent surgery, hip replacement, requiring active SNF (skilled nursing facility) care. Section N of the MDS documented that the facility assessed that the resident required administration of opioid pain management. Record review of the "History and Physical" (H&P) dated 6/25/25 for Resident #1, signed by her primary healthcare physician, Medical Doctor (MD) #1, revealed the resident was admitted after hospitalization for right total hip arthroplasty (THA) secondary to severe osteoarthritis/avascular necrosis unresponsive to conservative treatment who complained of postoperative right hip pain. The H&P included diagnoses of right hip pain and other acute postprocedural pain and treatment plans that included continuation of current medications and monitoring for pain control. Record review of the “Order Summary Report” revealed an order dated 6/13/25 for “Hydrocodone-Acetaminophen Oral Tablet 5-325 MG Give (1) tablet by mouth every (6) hours as needed for pain. Record review of the “Physician's Telephone Orders” dated 6/27/25 revealed “Discharge home with home health and medications." Record review of the “Discharge Summary/Instructions” dated 6/27/25 revealed the "Education regarding medications/treatments, exercises, or other services: Continue as ordered all medications. Follow up with primary care MD for refills". Record review of the “Transfer/Discharge Report” which included Current Medications List dated 6/27/25 for Resident #1 revealed Resident #1 discharged home on 6/27/25. The medication list included Hydrocodone-Acetaminophen Oral Tablet 5-325 MG one (1) tablet by mouth every 6 hours as needed for pain. Record review of the “Controlled Drug Record” revealed the Hydrocodone-Acetaminophen Oral Tablet 5-325 MG (quantity of 29) was destroyed on 7/17/25. Disposition of remaining doses indicated “doses mixed with cat litter/coffee grounds.”	F0550		