Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(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
M0000	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 Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements related to CI MS#2568468 and M500 was cited.	M0000		
M0500	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	M0500		

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

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M0500	Continued from page 1 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; 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	M0500		

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M0500	Continued from page 2 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 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	M0500		

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M0500	Continued from page 3 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 LICENSURE 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 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	M0500		

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M0500	Continued from page 4 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 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	M0500		

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M0500	Continued from page 5 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.”	M0500		