Mississippi State Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING | (X3) DATE SURVEY COMPLETED<br>**04/02/2026** |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **LAMAR HEALTHCARE & REHABILITATION CENTER** | **6428 US HIGHWAY 11 , LUMBERTON, Mississippi, 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) COMPLETION DATE |
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| M0000 | Initial Comments<br><br>The State Agency (SA) conducted an Annual Recertification survey and Complaint Investigation (CI MS #2795726) at the facility from 3/30/26 through 4/2/26. 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. CI MS #2795726 was investigated related to nutrition and weight loss, pressure ulcer, and accidents and M225, M615, and M645 was cited. During the recertification survey, M225, M500, M610, M840, and M1570 were cited. | M0000 | | |
| M0225 | 45.4.1 Nursing Facility<br><br>Nursing Facility. To be classified as a facility, the institution shall comply with the following staffing requirements:<br><br>1. Minimum requirements for nursing staff shall be based on the ratio of two and eight-tenths (2.80) hours of direct nursing care per resident per twenty-four (24) hours. Staffing requirements are based upon resident census. Based upon the physical layout of the nursing facility, the licensing agency may increase the nursing care per resident ratio.<br><br>2. Each facility shall have the following licensed personnel as a minimum:<br><br>a. Seven (7) day coverage on the day shift by a registered nurse.<br><br>b. A registered nurse designated as the Director of Nursing Services, who shall be employed on a full time (five [5] days per week) basis on the day shift and be responsible for all nursing services in the facility.<br><br>c. Facilities of one-hundred eighty (180) beds or more | M0225 | | |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| M0225 | Continued from page 1<br>shall have an assistant director of nursing services, who shall be a registered nurse.<br><br>d. A registered nurse or licensed practical nurse shall serve as a charge nurse and be responsible for supervision of the total nursing activities in the facility during the 7:00 a.m. to 3:00 p.m. and 3:00 p.m. to 11:00 p.m. shift. The nurse assigned to the unit for the 11:00 p.m. to 7:00 a.m. shift may serve as both the charge nurse and medication/treatment nurse. A medication/treatment nurse for each nurses' station shall be required on all shifts. This shall be a registered nurse or licensed practical nurse.<br><br>e. In facilities with sixty (60) beds or less, the director of nursing services may serve as charge nurse.<br><br>f. In facilities with more than sixty (60) beds, the charge nurse may not be the director of nursing services or the medication/treatment nurse.<br><br>3. Non-Licensed Staff. The non-licensed staff shall be added to the total licensed staff, to complete the required staffing requirements.<br><br>4. There shall be at least two (2) employees in the facility at all times in the event of an emergency.<br><br>This LICENSURE REQUIREMENT is NOT MET as evidenced by:<br><br>Based on interview, record review, and facility policy review, the facility failed to provide sufficient and competent nursing staff to meet the needs of residents, including failing to maintain the minimum nursing staffing ratio of 2.8, failing to designate a licensed nurse to serve as the charge nurse for each tour of duty, and allowing the Director of Nursing (DON) to function in the capacity of the charge nurse or Registered Nurse (RN) Supervisor when the facility census was greater than 60 residents with the potential to affect (89) of (89) residents residing in the facility.<br><br>Findings include:<br><br>A review of the facility's policy, "Staffing, Sufficient and Competent Nursing," revised August 2022, revealed, "…Our facility provides sufficient numbers of nursing staff with the appropriate skills and | M0225 | | |

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| M0225 | Continued from page 2<br>competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment…Policy Interpretation and Implementation Sufficient Staff…2. A licensed nurse is designated as a charge nurse on each shift…b. A 'charge nurse' is a licensed nurse with designated responsibilities that may include staff supervision, emergency coordination, provider or physician support and direct resident care…" The policy further revealed, "Sufficient Staff…2…c. The director of nursing services (DNS) may serve as the charge nurse only when the average daily occupancy of the facility is 60 or fewer…"<br><br>A record review of the "Facility Assessment" revealed "Staffing Hours per Resident Day" data for October 1 through December 31, 2025 documented Registered Nurse (RN) hours as "0.173" hours per resident per day, which equals ten (10) minutes of RN time per resident per day. The document further revealed an average resident census of "88.6" residents, which equals 15.3 RN hours per day based on the facility's reported staffing levels.<br><br>A record review of the staffing grid completed by the Director of Nursing (DON) revealed on 3/28/26, the staffing ratio was 2.7, which was less than the required minimum staffing ratio of 2.8.<br><br>A record review of the facility's daily assignments revealed that on 3/30/26 there was no designated Charge Nurse or RN Supervisor for the 6:00 PM to 6:00 AM shift or the 6:00 AM to 6:00 PM shift.<br><br>A record review of the facility's daily assignment document revealed the DON was listed as the "RN (Registered Nurse) Supervisor" on 3/16/26 and the census was 88. The record review further revealed on 3/17/26 the DON was listed as the RN Supervisor and the census was 90, on 3/26/26 the DON was listed as the RN Supervisor and the census was 94, and on 3/30/26 the DON was listed as the RN Supervisor and the census was 93.<br><br>On 3/31/26 at 3:43 PM, during an interview with the Director of Nursing (DON), she reported the facility did not have sufficient RN staffing to complete weekly wound assessments for residents with pressure ulcers. She reported the facility relied on the outpatient wound clinic to complete these assessments. She explained there was no weekly wound documentation that included measurements or assessments describing wound characteristics available for residents with wounds. | M0225 | | |

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| M0225 | Continued from page 3<br>On 4/1/26 at 2:35 PM, during an interview, the DON explained she also served in the capacity of the Infection Preventionist and was responsible for staffing, scheduling, and daily facility operations. She reported she had not had time to complete infection surveillance, track infections, or conduct infection control rounds for several months because she was working the medication cart or functioning as the nursing supervisor.<br><br>On 4/1/26 at 3:00 PM, during an interview with the Administrator, she stated the DON had sufficient time to complete infection prevention duties in addition to her other responsibilities.<br><br>On 4/2/26 at 7:45 AM, during an interview with the DON, she confirmed there was no designated charge nurse indicated on the daily assignment sheets because it was known by staff that the Licensed Practical Nurse (LPN) or cart nurse for the hall was in charge. She confirmed there was no charge nurse with specific duties including staff supervision, emergency coordination, physician liaison, and direct resident care. She stated she was unaware she was unable to function in the role of Nursing Supervisor due to the facility census and reported the facility had posted job openings and tried to hire RNs.<br><br>On 4/2/26 at 1:17 PM, during an interview with the Administrator, she stated the benefit to having a licensed nurse designated as the charge nurse is to reduce confusion and allow staff to know who is in charge. She stated she did not know that due to the facility census being over 60 residents, the DON could function in the capacity of the charge nurse or RN Supervisor. She reported the facility had placed job listings to recruit RNs. | M0225 | | |
| M0500 | 45.17.2 Residents' Rights<br><br>Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility:<br><br>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; | M0500 | | |

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| M0500 | Continued from page 4<br><br>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;<br><br>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;<br><br>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;<br><br>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;<br><br>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 | M0500 | | |

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| M0500 | Continued from page 5<br>the facility for any period of time in conformance with State law;<br><br>7. is free from mental and physical abuse;<br><br>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;<br><br>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;<br><br>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;<br><br>11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;<br><br>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);<br><br>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); | M0500 | | |

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| M0500 | Continued from page 6<br><br>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);<br><br>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<br><br>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.<br><br>This LICENSURE REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, interview, and record review, the facility failed to ensure the resident's right to have verbalized grievances addressed and resolved for one (1) of (19) sampled residents. Resident #25.<br><br>Findings include:<br><br>A record review of the "Admission Record" revealed the facility admitted Resident #25 on 5/24/24 with diagnoses including Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side.<br><br>A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/5/26 revealed Resident #25 had a Brief Interview for Mental Status (BIMS) score of (12), which indicated the resident's cognition was moderately impaired.<br><br>On 3/31/26 at 12:25 PM, during an observation and interview with the resident's Resident Representative (RR), she stated she was concerned regarding Resident #25's toenails. The RR removed the resident's socks, and her toenails were thick and had a yellow discoloration to both feet. The RR stated that she had been voicing her concerns for over a year to the facility staff, including Certified Nurse Aide (CNA) #1, that the resident needed to have a podiatry appointment, but nothing had been set up. | M0500 | | |

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| M0500 | Continued from page 7<br><br>On 4/1/26 at 2:14 PM, during an interview with Licensed Practical Nurse (LPN) #2, she reported she was aware that Resident #25's family requested for her to go to a podiatry appointment. She explained Resident #25's nails were thick and fungal in nature.<br><br>On 4/1/26 at 2:22 PM, during an interview with Certified Nurse Aide (CNA) #1, she reported concerns regarding the resident's toenails were brought to her in late February 2026 by the RR and she was aware that the resident had thick, yellow toenails.<br><br>On 4/2/26 at 9:26 AM, during an interview with CNA #3/Transportation Aide, she reported she is responsible for making appointments for residents. She stated she was aware that the RR had requested for Resident #25 to receive podiatry services but confirmed that no appointment had been scheduled.<br><br>On 4/2/26 at 1:42 PM, during an interview with the Director of Nursing (DON), she reported that when staff became aware of the RR's request, the nursing staff should have obtained a physician's order and scheduled a podiatry visit for Resident #25. | M0500 | | |
| M0610 | 45.21.2 Activities of daily living<br><br>Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well being. These shall include, but not be limited to:<br><br>1. Bath, dressing and grooming;<br><br>2. Transfer and ambulate;<br><br>3. Good nutrition, personal and oral hygiene; and<br><br>4. Toileting.<br><br>This LICENSURE REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, interviews, record review, and facility policy review, the facility failed to provide assistance with activities of daily living (ADLs) related to toenail care for one (1) of three (3) residents reviewed for ADL/Nail Care, Resident #76.<br><br>Findings include: | M0610 | | |

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| M0610 | Continued from page 8<br><br>A review of the facility's policy, "Fingernails/Toenails, Care of", dated 02/2018, revealed, "…The purpose of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infection…General Guidelines…6. Stop and report to the nurse supervisor if there is evidence of ingrown nails, infections, pain, or if nails are too hard or too thick to cut with ease…Documentation…6. If the resident refused the treatment, the reason(s) why and the intervention taken…"<br><br>On 3/30/26 at 2:39 PM, during an observation and interview, Resident #76's toenails were observed to be thick, long, curved, and excessive in length. The resident reported his toenails needed to be cut and stated he was unsure how long they had been in that condition.<br><br>On 3/31/26 at 10:34 AM, during an interview with Certified Nurse Aide (CNA) #2, she reported Resident #76 required extensive assistance with Activities of Daily Living (ADLs) except feeding and that staff assisted with bed baths. She reported that CNAs are expected to notify nursing staff if nail care is needed and stated she had not noticed any concerns with the resident's toenails.<br><br>On 3/31/26 at 11:10 AM, during an interview with Licensed Practical Nurse (LPN) #1, she reported the facility does not have an in-house podiatrist and residents must be sent out for podiatry services. She reported she had not been notified of any concerns regarding Resident #76's toenails.<br><br>On 4/1/26 at 10:45 AM, during an observation and interview with LPN #5, Resident #76's toenails were observed to be long and thick. LPN #5 confirmed the toenails were abnormal and stated the condition should have been reported and followed through by nursing staff. Resident #76 stated that "something needed to be done" and stated willingness to see a podiatrist.<br><br>On 4/1/26 at 11:05 AM, during an interview with the Director of Nursing (DON), she reported staff are expected to report changes in condition, including nail care, and ensure follow-up. She stated she had attempted to file the resident's toenails months prior, but the resident refused, and confirmed no follow-up was completed. She reported she was unsure whether a podiatry appointment had ever been scheduled.<br><br>On 4/1/26 at 11:36 AM, during an interview with CNA #3/Transportation Aide, she reported she had recently | M0610 | | |

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| M0610 | Continued from page 9<br>been notified the resident needed a podiatry appointment; however, no appointment had been scheduled.<br><br>On 4/2/26 at 2:50 PM, during an interview with the Administrator, she reported staff are expected to ensure residents' care needs are met.<br><br>A record review of the "Admission Record" revealed the facility admitted Resident #76 on 6/28/22 and readmitted on 1/22/26 with diagnoses including Encounter for Surgical Aftercare Following Surgery on the Genitourinary System.<br><br>A record review of the "Significant Change Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 1/29/26 revealed Resident #76 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated he was cognitively intact. A review of Section GG revealed he required assistance with self-care, including bathing and personal hygiene.<br><br>A record review of the "Order Summary Report" revealed Resident #76 had a physician's order, 9/8/22 for weekly head-to-toe body audits and to inform the supervisor or physician of any new skin concerns. | M0610 | | |
| M0615 | 45.21.3 Pressure sores<br><br>Pressure sores. Residents with a pressure sore shall receive necessary treatment and service to promote healing and prevent the development of new pressure sores. Residents without pressure sores will not develop pressure sores unless the residents' clinical condition indicates they were unavoidable.<br><br>This LICENSURE REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, interviews, record review, and facility policy review, the facility failed to ensure weekly wound assessments that included wound dimensions and characteristics were completed and documented for one (1) of two (2) residents reviewed for pressure ulcers. Resident #47.<br><br>Findings include:<br><br>A review of the facility's policy, "Pressure Ulcers/Skin Breakdown-Clinical Protocol," revised April 2018 revealed, "… Assessment and Recognition … 2…the nurse shall describe and document/report the following:<br>a. Full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue …" | M0615 | | |

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| M0615 | Continued from page 10<br><br>A record review of the “Order Summary Report” revealed a physician’s order dated 2/19/26 to remove old dressing, cleanse with wound cleaner, apply Santyl to the sacral wound as the primary dressing, apply Calcium Alginate, gauze, and cover with Allevyn border dressing as the secondary dressing, to be completed daily and as needed.<br><br>A record review of the “Wound Care Visit,” dated 3/10/26 revealed Resident #47 attended wound care at an outpatient provider. The visit documentation included assessment information that consisted of the wound dimensions, drainage, and wound characteristics and the “Impression” included that the wound had improved. A review of the next “Wound Care Visit,” dated 3/31/26 (three weeks later) revealed Resident #47 had another wound care visit at the outpatient provider. The documentation had wound information that included a complete assessment of the wound and documented the dimensions, drainage, and wound characteristics. The “Impression” included that the ulcer had improved.<br><br>A record review of the medical record for Resident #47 revealed there was no wound assessment documented by the facility between the outpatient wound care visits on 3/10/26 and 3/31/26.<br><br>On 3/30/26 at 11:24 AM, during an observation, Resident #47 was lying in bed on an air mattress with a positioning wedge in place between his knees.<br><br>On 3/30/26 at 11:50 AM, during an observation and interview with Resident #47 and his Responsible Representative (RR), the RR expressed concerns regarding the resident’s sacral pressure wound and reported she was unsure if the wound was being treated appropriately.<br><br>On 3/31/26 at 11:55 AM, during an interview with Licensed Practical Nurse (LPN) #1, she reported Resident #47 had a longstanding sacral wound and stated the facility does not have a dedicated wound care nurse. She explained that medication cart nurses complete wound care and treatments daily for assigned residents. She confirmed Resident #47 attended outpatient wound care and reported the outpatient provider assessed the wound and provided treatment orders.<br><br>On 3/31/26 at 3:43 PM, during an interview with the Director of Nursing (DON), she reported the facility did not have weekly wound reports that include measurements or assessments describing wound | M0615 | | |

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| M0615 | Continued from page 11<br>characteristics available. She confirmed there is no dedicated wound care nurse and that medication cart nurses completed treatments. She reported the facility relied on the outpatient wound care provider for wound assessments and monitoring. She acknowledged that pressure wounds should be assessed, measured, and documented weekly and explained that the facility did not have sufficient Registered Nurse (RN) staffing to complete weekly wound assessments.<br><br>On 4/2/26 at 10:01 AM, during a phone interview with the Registered Dietician (RD), she reported she completed onsite visits to the facility twice monthly and reviewed residents with wounds. She explained that she often has to request information from the DON because there are no weekly wound reports available in the medical record.<br><br>On 4/2/26 at 2:23 PM, during an interview with the Administrator, she reported she expected wound assessments to be completed as required.<br><br>A record review of the “Admission Record” revealed the facility admitted Resident #47 on 10/31/25 with diagnoses including Pressure Ulcer of Sacral Region, Stage 4.<br><br>A record review of the Significant Change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/30/26 revealed Resident #47 had a Brief Interview for Mental Status (BIMS) score of four (4), which indicated his cognition was severely impaired. A review of Section M revealed he had unhealed pressure ulcers, including one (1) Stage 3 pressure ulcer. | M0615 | | |
| M0645 | 45.21.9 Nutrition<br><br>Nutrition. Residents shall maintain acceptable parameters of nutritional status, such as body weight and protein levels, unless residents ' clinical condition indicates that this is unavoidable. All residents shall receive diets as orders by their physician or nurse practitioner/physician assistant. Residents identified with significant nutritional problems shall receive appropriate medical nutrition therapy based on current professional standards.<br><br>This LICENSURE REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, interview, and record review, the facility failed to ensure a resident received necessary nutritional and hydration care and services to maintain nutritional status, including failing to offer alternative food items when meals were refused, failing | M0645 | | |

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|---|---|---|---|---|
| M0645 | Continued from page 12<br>to consistently document meal intake and weights, and failing to monitor, evaluate, and implement timely interventions, which contributed to a delay in identifying and addressing significant weight loss for one (1) of two (2) residents reviewed for nutrition. Resident #47.<br><br>Findings include:<br><br>A record review of the “Admission Record” revealed the facility admitted Resident #47 on 10/31/25 with diagnoses including Pressure Ulcer of Sacral Region, Stage 4.<br><br>A record review of the “Order Summary Report” with active orders as of 4/2/26, revealed Resident #47 had a physician’s order, dated 3/9/26, for double portions of ordered diet for lunch and supper tray. Mighty shakes or equivalent supplement to be added to each tray and as a bedtime snack. Add a magic cup to lunch and supper tray. There were physician’s orders, dated 3/2/26 to document the percentage of meal intake at each meal and document total fluid intake at end of each shift. There was a physician’s order, dated 3/12/26 to check the resident’s weight each Thursday while RP (Responsible Party) in the room.<br><br>A record review of the “Weights and Vitals Summary” revealed Resident #47’s weight decreased from “128.0 pounds” on 9/10/25 to “123 pounds” on 1/22/26. It further decreased to “112.8 pounds” on 2/26/26, and then to “94.4 pounds” on 3/4/26 (six days later), representing a weight loss of 26.25% over six (6) months (9/10/25 to 3/4/26) and 16.46% within a 30-day period (2/26/26 to 3/4/26).<br><br>A record review of the Significant Change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/30/26 revealed Resident #47 had a Brief Interview for Mental Status (BIMS) score of four (4), which indicated the resident’s cognition was severely impaired. A review of Section K revealed his weight was recorded as 123 pounds and did not indicate a significant weight loss.<br><br>A record review of the “Documentation Survey Report” recorded by the Certified Nurse Aides (CNAs) for Resident #47 for February 2026 revealed documentation representing the amount eaten at each meal was not recorded for all meals on 2/2, 2/3, 2/6, 2/7, 2/8, 2/11, 2/14, 2/16, 2/17, 2/20, 2/21, 2/22, 2/25, 2/26, and 2/27 and for the supper meal on 2/12. This was a total of 46 times the resident’s meal intake was not recorded for the month of February. | M0645 | | |

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|---|---|---|---|---|
| M0645 | Continued from page 13<br><br>A record review of the Medication Administration Record (MAR) for March 2026, revealed there was no documentation recording the percentage of meal intake for Resident #47 for 15 meals recorded by the nurses on 3/2 (lunch and dinner), 3/6 (breakfast, lunch and dinner), 3/11 (dinner), 3/13 (dinner), 3/16 (dinner), 3/17 (breakfast, lunch and dinner), 3/21 (dinner), 3/22 (lunch and dinner), and 3/29 (dinner).<br><br>A record review of “Progress Notes” for Resident #47 revealed a Registered Dietician (RD) Assessment Summary, dated 02/28/2026 at 2:07 PM for “... wt.: (weight) 123-January; February weight is pending ..." There was also an RD Assessment Summary, dated 03/05/2026 at 7:25 AM, for “…wt.: 94 lb. weight is down -16.8% x 30 days, 23.6% x 90 days, and 26.6% x180 days..."<br><br>A record review of Resident #47’s Progress notes revealed a nurses note dated 03/04/2026 at 4:02 PM, revealed, “… dietician contacted to look at resident's weight decline and make any suggestions that may benefit resident ..."<br><br>On 3/30/26 at 11:21 AM, during an observation, Resident #47 was observed lying in bed with a thin appearance and visible bony prominences.<br><br>On 3/30/26 at 11:50 AM, during an observation and interview with Resident #47 and the resident’s Responsible Representative (RR), the RR expressed concerns regarding Resident #47’s weight loss and reported she had been visiting daily to assist with meals due to concerns that Resident #47 was not eating. She also expressed concerns that his weight was not being consistently monitored.<br><br>On 3/30/26 at 12:01 PM, during an observation, CNA #4 was assisting Resident #47 with feeding. Resident #47 attempted to push staff away, refused food, and told staff to eat the food.<br><br>On 3/30/26 at 2:00 PM, during an interview with CNA #4, she reported Resident #47 continued to refuse meals and demonstrated variable intake, sometimes eating and other times refusing. She reported Resident #47 could become combative during care and would push staff away during feeding attempts. CNA #4 reported that when Resident #47 refused meals, staff would encourage him to eat; however, she did not indicate that alternative food items were routinely offered following refusals.<br><br>On 3/31/26 at 11:25 AM, during a follow up interview | M0645 | | |

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|---|---|---|---|

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|---|---|---|---|---|
| M0645 | Continued from page 14<br>with CNA #4, she reported Resident #47 again refused lunch despite encouragement from staff and nursing. She reported Resident #47 was not offered an alternative meal or substitute food items after refusing the meal.<br><br>On 3/31/26 at 11:55 AM, during an interview with Licensed Practical Nurse (LPN) #1, she confirmed Resident #47 had experienced ongoing weight loss and frequently refused meals. She reported the facility had attempted interventions including supplements, appetite stimulants, and double portions. She confirmed weights were obtained by CNAs but were not obtained on consistent days, and she reported that all staff were able to the document meal intake of residents.<br><br>On 4/1/26 at 3:30 PM, during an interview with the Dietary Manager, she reported Resident #47 had periods of refusing meals and had been provided supplements, including Ensure Plus. She reported the RD monitors residents with weight loss and wounds.<br><br>On 4/1/26 at 4:30 PM, during an interview with the Director of Nursing (DON), she reported there was no staff member designated to consistently obtain weights and confirmed weights were not consistently obtained or entered into the medical record in a timely manner. She confirmed delays in documenting weights resulted in delayed identification of weight loss and delayed implementation of interventions. She reported interventions were initiated for Resident #47 after family concerns were raised. She confirmed Resident #47 had significant weight loss and acknowledged the lack of consistent monitoring contributed to delayed intervention.<br><br>On 4/2/26 at 10:01 AM, during a phone interview with the facility's RD, she reported she had been coming to the facility for years and visits twice a month to review residents, including those with significant weight loss. She reported she accesses weights through the computer during her visits and explained that when she documents weights as “pending,” it indicates no weight has been entered into the record. She reported that weights have been “hit and miss” at the facility for several months. She explained the DON contacted her on 3/5/26 regarding Resident #47’s weight loss, and after reviewing the medical record, she identified inconsistencies with both weights and meal intake documentation. She reported she reviewed Resident #47’s weights and stated the amount of weight loss, including approximately 18 pounds in six (6) days, was not normal and would not be expected from refusal of some meals alone. She reported she communicated with the facility, including the DON and Dietary Manager, and recommended | M0645 | | |

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|---|---|---|---|---|
| M0645 | Continued from page 15<br>providing Ensure Plus to increase protein intake and to continue offering Magic Cup supplements for Resident #47.<br><br>On 4/2/26 at 2:23 PM, during an interview with the Administrator, she reported she expects staff to obtain and document weights consistently and to notify the physician and RD of any significant weight loss in a timely manner. | M0645 | | |
| M0840 | 45.30.4 Menu<br><br>Menu. The menu shall be planned and written at least one week in advance. The current week's menu shall be approved by the dietitian, dated, posted in the kitchen and followed as planned. Substitutions and changes on all diets shall be documented in writing. Copies of menus and substitutions shall be kept on file for at least thirty (30) days.<br><br>This LICENSURE REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, interview, record review, and facility policy review, the facility failed to provide residents with alternate food options of similar nutritive value for one (1) of (19) sampled residents with the potential to affect all 89 residents in the facility. Residents #12<br><br>Findings included:<br><br>A review of the facility's policy "Alternate Foods for Food Preferences" with reviewed date of 12/23 revealed "… Alternate foods and beverages are offered to residents who refuse offered off regular menu and is, served to meet individual … preferences, or requests. Procedure: … 4. The nursing assistant, on observing that a resident is refusing food, offers the always available alternate food to the resident…"<br><br>A record review of the facility's "Always Available Menu" revealed "Grilled cheese, hamburger, chicken tenders, soup/salad (and/or) half of a sandwich, pimento cheese sandwich, peanut butter and jelly sandwich, and deli sandwich."<br><br>A record review of the facility's menu, "Fall/Winter 2025/2026 Week 1 Alternates and Modified Items" revealed there were menu alternatives for each meal and each day of the week. The alternative menu included full meal options that included items such as sliced turkey, steak fingers, smoked sausage, but did not include the items listed on the "Always Available Menu." The alternative menu was signed by the | M0840 | | |

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|---|---|---|---|---|
| M0840 | Continued from page 16<br>Registered Dietician (RD).<br><br>Resident #12<br><br>On 03/30/2026 at 11:55 AM, during an observation and interview, Resident #12 was eating the lunch meal which consisted of coleslaw, pulled pork, and baked beans. He reported that he doesn't always like what is served.<br><br>On 03/31/2026 at 10:54 AM, during an interview, Certified Nurse Assistant (CNA) #4 stated that Resident #12 eats well depending on the menu. She reported that on the previous evening, the resident did not like the chicken alfredo served for dinner. CNA #4 explained the facility does not offer alternate meals, but that residents can get an item from the “Always Available” menu.<br><br>A record review of Resident #12 “Admission Record” revealed the facility admitted the resident on 7/22/24 with diagnoses including Unspecified Dementia.<br><br>A record review of Resident #12’s “Order Summary Report” revealed he had a physician’s order, dated 7/22/24 for a regular diet, regular texture, and regular/thin consistency.<br><br>A record review of Resident #12’s Quarterly Minimum Data (MDS) with an Assessment Reference Date (ARD) of 1/30/26 revealed he had a Brief Interview for Mental Status (BIMS) Summary Score of 07, which indicated his cognition was severely impaired.<br><br>On 04/01/2026 at 2:00 PM, during an observation, signage was posted outside of the main dining room that included the menu for breakfast, lunch, and dinner, but there was no alternative menu listed for lunch or dinner.<br><br>On 04/01/2026 at 3:30 PM, during an interview, Dietary Manager #1 stated the facility does not offer alternative meals for lunch or dinner, because the facility has an “Always Available” menu in place. The Dietary Manager confirmed the always-available options included items such as soup, sandwiches, grilled cheese, burgers, salads, and chicken tenders.<br><br>On 04/02/2026 at 10:01 AM, during a phone interview, the facility’s RD stated she was not aware that alternative meals were not being prepared and offered per the alternate menu that she signs and approves for the facility. She reported that she knew the facility provided additional items to the residents from the “Always Available” menu” but she was unaware that the | M0840 | | |

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|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **LAMAR HEALTHCARE & REHABILITATION CENTER** | **6428 US HIGHWAY 11 , LUMBERTON, Mississippi, 39455** |

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|---|---|---|---|---|
| M0840 | Continued from page 17<br>facility had replaced the alternate menu she approves with the “Always Available” menu. She confirmed that selecting items from the “Always Available” menu alone may not provide equivalent nutritional value, as meals are required to include meat, starch, and vegetables to meet nutritional standards.<br><br>On 04/02/2026 at 2:23 PM, during an interview with the Administrator, she reported that currently the facility did not prepare meals using both the regular menu and the alternate menu. She expected staff to honor residents' choices and offer other meal items from the “Always Available” menu when residents do not eat the meal provided. | M0840 | | |
| M1570 | 48.58.1 Infection Control<br><br>The following infection control standards shall be met:<br><br>1. The facility must maintain and document an effective infection control program that protects patients, families, visitors, and facility personnel by preventing and controlling infections and communicable diseases.<br><br>2. The facility must have an active surveillance program that includes specific measures for prevention, early detection, control, education, and investigation of infections and communicable diseases in the facility. There must be a mechanism to evaluate the effectiveness of the program(s) and take corrective action when necessary. The program must include implementation of nationally recognized systems of infection control guidelines to avoid sources and transmission of infections and communicable diseases.<br><br>3. The facility must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions.<br><br>This LICENSURE REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, staff interview, record review, and facility policy review, the facility failed to establish and maintain an effective infection prevention and control program when the designated Infection Preventionist, who was the Director of Nursing (DON), did not have sufficient time to perform infection prevention and control duties, resulting in a failure to conduct infection surveillance, track and | M1570 | | |

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|---|---|---|---|

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|---|---|---|---|---|
| M1570 | Continued from page 18<br>trend infections, and perform infection control rounds for three (3) of five (5) months reviewed, which had the potential to affect all (89) residents in the facility.<br><br>Findings include:<br><br>A review of the facility's policy, "Surveillance for Infections," revised July 2016, revealed, "…Policy Interpretation and Implementation…1. The purpose of the surveillance of infections is to identify both individual cases and trends of epidemiological significant organism and Healthcare-Associated Infections, to guide appropriate interventions, and to prevent future infections…8. The Charge Nurse will notify the Attending Physician and the Infection Preventionist of suspected infections. a. The Infection Preventionist and the Attending Physician will determine if laboratory tests are indicated…b. The Infection Preventionist will determine if the infection is reportable…9. If transmission-based precautions or other preventative measures are implemented to slow or stop the spread of infection, the Infection Preventionist will collect date to help determine the effectiveness of such measures…"<br><br>A review of the facility's policy, "Compliance Rounds," revised January 2012, revealed, "…The Infection Preventionists shall conduct unannounced periodic infection control rounds. Policy Interpretation and Implementation…2. Infection control compliance rounds should be conducted at least quarterly or at a frequency determined by the IC (Infection Control) Committee or Quality Assurance and Assessment Committee…3. The 'Monitoring Compliance with Infection Control Checklist' should be completed during each periodic compliance round."<br><br>A review of the facility's infection control records revealed there were no infection surveillance logs available to review that documented infection tracking or trending. There were also no infection control meeting minutes to review that documented infection control meetings were conducted for oversight.<br><br>On 4/1/26 at 2:35 PM, during an interview, the Director of Nursing (DON) explained she also served as the Infection Preventionist and was responsible for staffing, scheduling, and daily facility operations. She reported she had not had time to complete infection surveillance, track infections, or conduct infection control rounds for several months because she was working the medication cart or functioning as the nursing supervisor. | M1570 | | |

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|---|---|---|---|

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|---|---|---|---|---|
| M1570 | Continued from page 19<br><br>On 4/1/26 at 3:00 PM, during an interview, the Administrator explained she believed the DON had sufficient time to complete infection prevention duties in addition to her other responsibilities. | M1570 | | |