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 _____	05/16/2019

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LAMAR HEALTHCARE & REHABILITATION CEI	6428 US HIGHWAY 11 LUMBERTON, MS 39455

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M 000	Initial Comments ****Amended 2567**** After administrative review, this survey was re-opened from 5/14/1905/16/19, by Health Management Solutions (HMS), on behalf of the MS State Department of Health. Based on further investigation, the following changes were med to the 2567: M225, M500, M610, and M915 continued without changes. M625 was modified. M655, M640, M645, and M680 were deleted. The State Agency (SA) contract surveyors determined during an annual recertification survey, conducted from 2/25/19-2/28/19, the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm with deficiencies cited at M225, M500, M610, M625, M655, M640, M645, M680 and M915. The facility was licensed for 120 beds and had a census of 88.	M 000		
M 225	45.4.1 Nursing Facility Nursing Facility. To be classified as a facility, the institution shall comply with the following staffing requirements: 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	M 225		6/18/19

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

Electronically Signed | 04/15/19

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M 225	Continued From page 1 agency may increase the nursing care per resident ratio. 2. Each facility shall have the following licensed personnel as a minimum: a. Seven (7) day coverage on the day shift by a registered nurse. 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. c. Facilities of one-hundred eighty (180) beds or more shall have an assistant director of nursing services, who shall be a registered nurse. 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. e. In facilities with sixty (60) beds or less, the director of nursing services may serve as charge nurse. 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.	M 225		

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M 225	Continued From page 2 3. Non-Licensed Staff. The non-licensed staff shall be added to the total licensed staff, to complete the required staffing requirements. 4. There shall be at least two (2) employees in the facility at all times in the event of an emergency. This Statute is not met as evidenced by: Based on record review and staff interview, the facility failed to meet the minimum staffing requirements for six (6) of 14 days reviewed for daily staffing. Findings Include: A review of the State of Mississippi regulations for the Aged and Infirm, revealed: 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. Review of the facility staffing, for the period of 2/12/19 through 2/25/19, revealed the facility did not meet the minimum staffing requirement of 2.80 on February 12-17, 2019 and February 23, 2019. An interview with the Director of Nursing (DON), on 2/27/19 at 9:10 AM, revealed the facility had several staff situations that involved personal issues during the two (2) weeks reviewed. The DON stated, those situations included a staff member's husband being murdered, another staff member's child being kidnapped, and a couple of no call/no show from recently hired staff. The DON revealed that he was aware of the minimum staffing requirement. The DON stated, he has	M 225	This Plan of Correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. 1. Root Cause Analysis was completed by the Quality Assurance and Performance Improvement (QAPI) Committee on 3/14/19 and again on 6/7/19. Based on findings the facility failed to meet the states minimum staffing requirement for 6 of 14 days reviewed by surveyor. A shift bonus program was put into affect on 11/6/18 for clinical staff as well as a sign on bonus offered for CNAs. On 12/1/18 an attendance bonus was implemented. On 12/4/18 the shift differential was increased. An online ad is posted as well. The facility has hired 5 additional clinical staff since the date of the survey exit of 2/28/19. 2. All residents have the potential to be affected by this practice. 3. Education was initiated by the Director	

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M 225	Continued From page 3 made every effort to make sure that the facility meet and/or exceed the required 2.80 ratio. The DON further revealed the facility has been utilizing (Name of Job website) to post job positions and have offered bonus opportunities to recruit staff. During an interview, on 2/27/19 at 9:40 AM, the Administrator stated, although the regulation states 2.80 as the minimum, we try to staff according to the acuity of the residents and to meet the needs of the residents. The Administrator revealed, they had several things to happen with employees recently. The Administrator stated, "We have been busting our butts to get staff here."	M 225	of Nurses (DON) on 3/12/19 and was completed on 4/3/19 with current clinical staff regarding minimum state staffing requirements for clinical staff and is ongoing. Newly hired clinical staff to be educated by the Staff Development Nurse during orientation regarding minimum state staffing requirements. 4. DON to monitor staffing 5 days a week to ensure state minimum staffing requirements are met. These staffing numbers will be presented in the monthly QAPI Committee Meeting for any further recommendations for 90 days.	
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;	M 500		6/18/19

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M 500	Continued From page 4 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; 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,	M 500		

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M 500	Continued From page 5 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 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;	M 500		

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M 500	Continued From page 6 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 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:	M 500		

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M 500	Continued From page 7 Level II Based on observation, record review, and review of the "Quality of Life - Dignity" policy, the facility failed to routinely ensure resident dignity for one (1) of 18 sampled residents, when the urinary catheter bag was uncovered/not in a privacy bag for Resident (R) #71. Findings include: Review of facility policy, "Quality of Life - Dignity," revised August 2009, indicated: Demeaning practices and standards of care that compromise dignity are prohibited. Staff shall promote dignity and assist residents as needed by: Helping the resident to keep urinary catheter bags covered. Resident #71 was observed on 02/25/19 at 9:32 AM; he was resting in bed in his room. His urinary catheter drainage bag was hanging on the bedrail toward the hallway, uncovered, and visible to anyone in the hallway. Observation on 02/25/19 at 1:00 PM, showed Resident #71's urinary catheter drainage bag was hanging on the bedrail toward the hallway, uncovered, and visible to anyone in the hallway, including the resident's mother and sister, who were visiting. Observation on 02/26/19 at 9:40 AM, showed Resident #71 resting in bed in his room. His urinary catheter drainage bag was hanging on the bedrail toward the hallway, uncovered, and visible to anyone in the hallway. Observation on 02/26/19 at 10:55 AM, showed Resident #71 resting in bed in his room. His urinary catheter drainage bag was hanging on the	M 500	1. Root Cause Analysis was completed by the Quality Assurance and Performance Committee(QAPI) on 3/14/19 and again on 6/7/19. Based on findings the Certified Nursing Assistant failed to ensure resident #71 urinary drainage bag was covered on 2/25/19 and 2/26/19. Resident #71 urinary drainage bag was replaced with a fig leaf urinary drainage bag with a built in dignity cover on 3/1/19 per the Director of Nurses(DON). 2. All residents have the potential to be affected by this practice. 3. Education was initiated by the Director of Nurses(DON) on 3/12/19 for current clinical staff and was completed on 4/3/19 regarding urinary drainage bags and dignity. Education was initiated with the clinical staff by the Staff Development Nurse on 6/11/19 and 6/13/19. Newly hired clinical staff will be educated by the Staff Development Nurse regarding dignity with urinary drainage bags during orientation. 4. DON/Unit Manager to conduct a Quality Review of dignity with urinary drainage bags weekly x 4 weeks then monthly x 3 months. Quality Review to be modified based on findings. The findings of the Quality Review to be reported in the monthly QAPI Committee Meeting and reviewed by the Interdisciplinary Team for any further recommendations for 90 days.	

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M 500	Continued From page 8 bedrail toward the hallway, uncovered, and visible to anyone in the hallway. Review of the February 2019 "Physician Orders", for Resident #71, revealed to check placement, patency, and drainage to Foley catheter every shift and as needed..	M 500		
M 610	45.21.2 Activities of daily living 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: 1. Bath, dressing and grooming; 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4. Toileting. This Statute is not met as evidenced by: Level II Based on observation, interview, record review, and review of the "Repositioning" policy, the facility failed to reasonably accommodate one (1) of one (1) resident, included in the sample, with specialized positioning dining support needs, to achieve more independent functioning, dignity, and well-being out of 18 sampled residents, Resident (R) #41. Findings include: Review of the facility policy on "Repositioning," revised May 2013, under the section for	M 610	1. Root Cause Analysis (RCA) was completed by the Quality Assurance and Performance Improvement (QAPI) Committee on 3/14/19 and again on 6/7/19. Based on findings the facility failed to ensure resident #41 was properly positioned during meal time on 2/25/19. No negative outcomes for Resident #41 identified upon assessment by the Director of Nurses on 2/27/19. Resident #41 was screened for positioning by an Occupational Therapist on 2/27/19 and a wedge cushion was implemented for proper positioning while in bed on 2/27/19 by an Occupational Therapist. 10	6/18/19

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M 610	Continued From page 9 "Repositioning the Resident in Bed" which documented the following instructions, "Check the care plan . . . to determine resident's specific positioning needs." On 02/25/19 at 12:05 PM, an observation was conducted of Resident #41, being served lunch in her room. The surveyor was positioned in the hallway adjacent to her bedroom, with an unobstructed view of Resident #41 and her side of the room. Certified Nursing Assistant (CNA) #15 carried a food tray into the room and placed it on the surface of the rolling bed table positioned across Resident #41's bed. Resident #41 was sleeping in her bed. CNA #15 said R #41's name and roused her. CNA #15 raised the head of the bed, removed lids from the plated foods, and placed dining utensils on the right side of the tray. CNA #15 did not adjust the height of the bed and did not adjust the height of the rolling bed table. The surface of the bed table was at the same height as Resident #41's face. CNA #15 asked, "You OK?" Resident #41 nodded her head "Yes". CNA #15 left the room, returned with Resident #41's roommates' food tray, and began assisted her with setting up her meal. CNA #15 then left the room and continued delivering food trays to other resident rooms. Resident #41 picked up her spoon and raised her right arm above the tray to scoop food from a bowl. As she did, her upper torso began slowly sliding to the right side of her bed. As she continued trying to scoop food from the containers on her tray, her upper torso continued to slide to the right until her face was resting on the bed mattress to the right of the pillows at the head of her bed. In this bent over position, Resident #41 continued attempting to dine, by reaching her left hand to the tray above her, and feeling the foods in the containers. Her hand and arm moved slowly and tremored. She	M 610	additional residents with possible positioning problems were screened by a Certified Occupational Therapy Assistant on 3/9/19 and no additional recommendations were warranted at that time. All residents are screened by therapy quarterly and as needed to identify any declines in functional status. 2. All residents have the potential to be affected by this practice. 3. Education was initiated by the Director of Nurse(DON) on 3/12/19 for current clinical staff and was completed on 4/3/19. Education was initiated by the Staff Development Nurse for clinical staff on 6/11/19 and 6/13/19 regarding proper positioning of residents. All newly hired clinical staff will be educated during orientation by the Staff Development Nurse during orientation regarding proper positioning of residents. 4. Director of Nurses/Unit Manager to conduct a Quality Review of proper resident positioning weekly x 4 week then monthly x 3 months. Quality Review to be modified based on findings. The findings of the Quality Review to be reported in the monthly QAPI Committee Meeting and reviewed by the Interdisciplinary Team for any further recommendations for 90 days.	

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M 610	Continued From page 10 gripped a small bowl that contained Tetrazzini and lowered it to the mattress near her face where she began finger feeding bits of the food into her mouth with her head still resting on the mattress. There was some spillage with food debris accumulating in Resident #41's bed near her face. As she could not see her plate with her head lower than the food tray, she used her left hand to feel around on her tray to try and acquire other food items. These attempts were not successful. During these observations no staff members checked on the progress of the meals underway in Resident #41's room. CNA #2, also delivering food trays to resident's rooms, looked at the surveyor standing in the hallway outside Resident #41's room. CNA #2 stopped delivering food trays, walked down the hall, and entered Resident #41's room. CNA #2 observed Resident #41's poor dining position, moved across the room to her, and said, "Let's get you sitting up, so you can eat better." CNA #2 moved the rolling bed tray away from the bed, lifted Resident #41's torso into an upright position in the center of her mattress, and picked up food debris from the bed where Resident #41 had moved her bowl. CNA #2 reclined the head of the bed and assisted Resident #41 into a midline and upright orientation to her food. She placed a rolled-up towel along Resident #41's right side, lowered the bed, and positioned the tray near Resident #41's lap by lowering the rolling table surface. CNA #2 asked Resident #41, "Is that better?" and she stated said, "Yes." On 02/25/19 at 12:30 PM, an interview was initiated with CNA #2. She reported Resident #41 tended to lean to the right in her bed, so during meals staff usually used a rolled-up towel on her right side to prevent her from sliding to the right.	M 610		

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M 610	Continued From page 11 She said she learned about this intervention by talking to other staff. She said she did not believe this intervention was included in Resident #41's Care Plan. She said it was standard practice for CNAs to make sure table tray surfaces were at the optimal height as part of setting up meals for residents who dined in their rooms. On 02/25/19 at 12:42 PM, an interview was initiated with CNA #15. She confirmed delivering Resident #41's lunch tray and setting up her meal. She reported being aware that Resident #41 tended to lean to her right in bed but didn't observe her doing so when she served her meal tray. CNA #15 confirmed she did not make sure Resident #41's bed table was lowered to the appropriate height after placing the tray on her bed table surface. She confirmed she did not take any action to support Resident #41's position in her bed in preparation for the meal. She said she was rushing trying to get the lunch trays to residents. She said she did not recall any instructions about the use of positioning support for Resident #41 during meals. On 2/26/2019 at 10:15 AM, an interview was initiated with the Director of Nursing. He verified this incident of positioning for Resident #41, did not represent accepted practice at the facility and described actions underway to improve accommodations and supports for the residents of the facility. Review of the Resident #41's "Minimum Data Set" (MDS), dated 12/05/18, identified her relevant diagnoses as "Chronic Obstructive Airway Disease, Heart Disease, Atrial Fibrillation, and Gastroesophageal Reflux Disease." Resident #41's "Functional Status in Bed Mobility (how resident moves to and from lying position, turns	M 610		

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 _____	05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAMAR HEALTHCARE & REHABILITATION CEI	6428 US HIGHWAY 11 LUMBERTON, MS 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) COMPLETE DATE
M 610	Continued From page 12 side to side and positions body while in bed)" as "Total dependence - full staff performance" . . . requiring "one-person physical assist."	M 610		
M 625	45.21.5 Range of motion Range of motion. Residents with limited range of motion shall receive treatment and services to increase range of motion or prevent further decline in range of motion. This Statute is not met as evidenced by: Level II Based on interview, record review and review of the facility's policy, the facility failed to implement the therapy restorative nursing plan for two (2) residents, Resident #70 and Resident #39, of seven (7) residents reviewed for restorative nursing. Findings include: Review of the facility's policy titled, "Restorative Nursing Services", revised July 2017, indicated, "Residents will receive restorative nursing care as needed to help promote optimal safety and independence ...2. Residents may be started on restorative nursing ...when discharged from rehabilitative care. 3. Restorative goals and objectives are individualized and resident-centered, and are outlined in the resident's plan of care ..." During an interview on 5/15/19 at 3:38 PM, the Therapy Rehab Director (TRD) stated that Therapy has always screened each resident quarterly and more often if the resident experiences a fall or if nursing noticed a change	M 625	1. Root Cause Analysis was completed by the Quality Assurance and Performance Improvement (QAPI) Committee on 3/14/19 and again on 6/7/19. Based on findings the facility failed to provide care and services to maintain, improve, or prevent potentially avoidable declines in range of motion and mobility for residents #39, and #70. Resident #39 was screened by a Certified Occupational Therapy Assistant and put on case load on 3/12/19. Resident #70 was screened by a COTA on 3/19/19 and it was determined an evaluation was not needed at that time due to resident #70 being a baseline. All residents are screened quarterly and as needed by the therapy department for any declines in functional status. 2. All residents have the potential to be affected by this practice. 3. Education was initiated for clinical staff on 3/12/19 by the Director of Nurses (DON) and was completed on 4/3/19 regarding providing care and services to maintain, improve, or prevent potentially	6/18/19

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M 625	Continued From page 13 in the resident. She stated that Therapy was conducting these screenings, which if the results of the screening indicated therapy, an evaluation and treatment program would be conducted. She stated that the therapy evaluation and treatment would include Physical, Occupational and Speech therapy. She stated since the survey on 2/28/19, Therapy has continued to conduct the therapy screening quarterly and more often if warranted and if the resident required therapy, the therapy department would keep that resident on their case load until the resident's goals are met. After the resident met their goals, Therapy would screen again quarterly and more often if necessary. If Therapy determined an evaluation is warranted, Therapy would add this resident to their case and and develop the therapy plan. She stated that Therapists has been providing the therapy for any resident warranted, until the resident meets their goals. Resident #70 Review of the medical record revealed Resident #70 was evaluated and admitted to physical therapy (PT) and occupational therapy (OT) on 8/20/18. On 10/18/18, Resident #70 met his therapy goals. Review of the "PT/OT Discharge Summary" dated 10/18/18, indicated, "Discharge Disposition: skilled services no longer justified ...Follow-up Care Recommended: Restorative treatment ..." Review of the "Restorative Plans" dated 10/17/18, documented that the therapist provided the restorative plan to Licensed Nurse (LN) #9 on 10/17/18. The document indicated signatures by both the therapist and LN #9. Review of the restorative documents indicated: 1. Restorative Plan-Active Range of Motion. Instructions: perform activity in : Sitting/Standing/Lying Down,	M 625	avoidable declines in range of motion and mobility of residents. Education was initiated by Staff Development Nurse on 6/11/19 and 6/13/19 with current clinical staff regarding providing care and services to maintain, improve, or prevent potentially avoidable declines in range of motion and mobility for residents. All newly hired clinical staff will be educated by the Staff Development Nurse during orientation regarding providing care and services to maintain, improve, or prevent potentially avoidable declines in range of motion and mobility for residents. A restorative contract went into effect on 4/10/19 with the therapy department and 2 restorative aides have been hired and interviews continue for additional restorative staff. 4. DON/Unit Manager to conduct a Quality Review of residents who have had any declines in range of motion and mobility weekly x 4 weeks then monthly x 3 months. Quality Review to be reported in the monthly QAPI Committee Meeting by the Interdisciplinary Team for any further recommendations for 90 days.	

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M 625	Continued From page 14 Other sitting and standing special instructions:...kickouts (knee flexion and extension) side kickouts (hip abduction/adduction) heel raises (plantar/dorsal flexion) marching (hip flexion) ball squeeze, wheelchair pushups, bike x 10-15 minutes. Repetition: repeat all 20 times per set. Do three (3) session per day. 2. Restorative Plans-Gait. Instructions: Perform gait using: rolling walker/standard walker/wheelchair/cane. Special instructions: using gait belt GT, assist patient from therapy to his room. Patient requiring stand by assist. Distance to walk: 75-100 feet. Number of repetitions: 1-2. Do one (1) session per day. Review of Resident #70's care plan revealed that the "Restorative Plan" had not been included. Interview with the Rehab Director (RD) on 5/15/19 at 3:38 PM, revealed that once therapy educates nursing staff on the restorative plan, then therapy turns over the care of the resident to nursing. The Rehab Director stated that therapy creates the restorative plan, then nursing adds the restorative plan to the resident's care plan and implements the plan. During this interview, the RD stated that Resident #70 received therapy from 8/20/18 through 10/18/18, and was discharged to restorative nursing. She stated that on 11/19/18, the resident was admitted to the hospital, due to his respiratory condition, and returned from the hospital on 11/20/18. She stated that Resident #70 was picked up by therapy until he was discharged from therapy on 1/28/19, due to his goals were met. The RD stated that Resident #70 was then screened quarterly, the last on 3/12/19, with the recommendation that a therapy evaluation and treatment was not needed. The RD stated that meant that Resident #70 had not declined from	M 625		

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M 625	Continued From page 15 his functional status when he was discharged from therapy. She stated that therapy will continue to screen the resident quarterly, or more often, if nursing notices a change in the resident. Review of the "Therapy Services Screening" document dated 3/12/19, indicated: "Patient observed and evaluation is not recommended". Resident #39 Review of the medical record revealed Resident #39 was evaluated and admitted to PT on 6/198/18. Resident #39 met her PT goals on 7/23/18. Review of the "PT Discharge Summary", dated 7/23/18, indicated, "Discharge Disposition: skilled services no longer justified ... Follow-up Care Recommended: Restorative treatment ..." Review of the "Restorative Plan" dated 7/19/18, documented that the therapist provided the restorative plan to the previous Director of Nursing (DON) on 07/23/18. This document indicated signatures by both the therapist and the previous DON. Review of the "Restorative Documents", revealed: 1. Restorative Plan-Active Range of Motion. Instructions: Perform activity in : Sitting/Standing/Lying Down...kickouts (knee flexion and extension)-side kickouts (hip abduction) heel raises (plantar flexion) bike times 10-15 minutes, Repetition: Repeat all 20 times per set. Do three (3) session per day. 2. Restorative Plans-Gait. Instructions: Perform gait using: rolling walker/standard walker/wheelchair/cane. Special Instruction: walk to dine with patient time (x) two (2). Distance to walk: 150 feet. Number of repetitions-three (3). 3. Repetition: Do 1-2 sessions per day. The DON was interviewed on 02/27/19 at 3:45	M 625		

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M 625	Continued From page 16 PM. He verified there had been no formal restorative nursing program in the building since the previous Restorative Nurse was separated from the facility in November 2018. He said when he was hired as the DON, he received a staffing schedule which included two (2) Restorative Nursing Assistants (RNAs), but neither of them ever reported to work. The DON said he never saw them and never met them. The facility terminated both RNAs for abandonment of job duties. He state that he had not yet reached the point where he could fill the vacancies in a formal restorative program. The DON explained, "We are struggling to meet the basic clinical needs of the residents". In an interview with the DON on 5/16/19 at 3:00 PM, the DON confirmed that he had reviewed Resident #70 and Resident #39's clinical records and the documents in the medical record's room, that were loose in a box for various residents, and that he could not locate any documentation that the restorative plan was implemented by nursing for either resident. Also, during this interview the DON confirmed that neither resident's care plan addressed the restorative plan developed by therapy. The DON confirmed the restorative plans were not implemented, as recommended by therapy and should have been completed by staff during routine care. Review of therapy quarterly screenings for Resident #39, dated 8/24/18, 11/27/18, 12/11/18, and 2/29/19, indicated "Patient observed and evaluation not recommended". In an interview on 5/15/19 at 3:38 PM, the Rehab Director stated that even though Resident #39 was referred to restorative nursing on 7/24/18, therapy continued to screen the resident at least	M 625		

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M 625	Continued From page 17 quarterly and more often if nursing noticed any changes in the resident. The RD stated based on these screenings, Resident #39 did not decline from her functional status that was achieved on 7/23/18, when she was discharged from therapy. The RD stated nursing noticed Resident #39 was limping on 3/12/19, a screening was conducted, and an evaluation was recommended. The RD stated the resident was being seen by her physician for a problem with her toe nail, and requested to wait until the toe healed before further therapy evaluation and treatment.	M 625		
M 915	45.31.9 Equipment and Utensil Construction Equipment and Utensil Construction. Equipment and utensils shall be constructed so as to be easily cleaned and shall be kept in good repair. This Statute is not met as evidenced by: Level II Based on observation, interview, record review, and review of the "Refrigerators and Freezers" policy, the facility failed to ensure the kitchen and dining services were sanitary for 86 out of 88 current residents and had: -cooking trays free from grease build-up; -cooking pans free from debris; and -stove burner grates in good repair. Findings include: The facility policy "Refrigerators and Freezers" from the Food and Nutrition Services Policy and Procedure Manual (Revised December 2014), revealed the following under Policy Interpretation and Implementation "8. Supervisors will be responsible for ensuring food items in pantry,	M 915	1. Root Cause Analysis was completed by the Quality Assurance and Performance Improvement Committee(QAPI)on 3/14/19 and 6/7/19. Based on findings the facility failed to remove expired milk from the cooler, replace pitted trays with grease build up, and replace stove grates. Expired milk was removed from the milk cooler and placed in the main cooler with a label of expired milk on the crate by the dietary manager on 2/25/19. On 2/28/19 the expired milk was picked up and credit was given by the vendor. On 2/28/19 trays were ordered by the Dietary Manager and delivered on 2/28/19 to replace the pitted trays with grease that could not be removed. On 2/26/19 new stove grates were ordered by maintenance and they were delivered and installed on 3/25/19 by	6/18/19

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M 915	Continued From page 18 refrigerators, and freezers are not expired or past perish dates. Supervisors should contact vendors or manufacturers when expiration dates are in question or to decipher codes...9. Supervisors will inspect refrigerators and freezers for gasket condition, fan condition, presence of rust, excess condensation and any other damage or maintenance needs. Necessary repairs will be initiated immediately. Maintenance schedules per manufacturer guidelines will be scheduled and followed." During the initial walkthrough of the kitchen on 02/25/19, commencing at 11:15 AM, a food storage cart was observed with two (2) trays caked with grease around the exterior lips of the pans. Per concurrent interview with the Dietary Manager (DM), the DM explained the trays were used exclusively for cooking but were still in need of cleaning. During a subsequent interview with the DM on 02/28/19 at 9:15 AM, he stated the trays could not be cleaned any further and had placed an order to replace 10 of them. Examination of the kitchen stove on 02/25/19 at approximately 11:15 AM, revealed two (2) grates were rusted with missing tips. The DM was present for the observation and stated he would contact maintenance for replacement. On 02/28/19, commencing at 9:15 AM, in a subsequent tour of the kitchen, observation revealed one (1) of three (3) facility's food preparation pans was noted to be pitted and coated with a film-like substance that could not be removed when the DM attempted to remove it with his finger. The DM stated in response to the observation he would also order new cooking	M 915	maintenance. 2. All residents who receive food from Dietary have the potential to be affected by this practice. 3. In-service education was completed on 3/1/19 by the Dietary Manager with all dietary staff regarding expired food items and policy and procedure for removal of expired food items. In-service education was completed on 5/27/19 for all of the dietary staff by the Administrator on storage, preparation and sanitation. A review of all pans and bake ware was conducted by the Dietary Manager on 2/25/19. The vendor was contacted by the dietary manager about their practice of removing expired milk upon delivery of new product on 2/25/19. Registered Dietitian will perform a Quality Review for kitchen food service observation quarterly that includes expired milk, pitted pans with grease build up, and stove grates in good repair. 4. 5 x a week observation and sanitation audits will be completed by the Dietary Manager for expired milk, pitted trays, trays with grease build up, and stove grates not in good repair x 4 weeks. Administrator will complete weekly observation rounds and reviews of documented audits x 4 weeks. The findings of the Quality Review to be reported in the monthly QAPI Committee Meeting and reviewed by the Interdisciplinary Team for any further recommendations.	

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M 915	Continued From page 19 pans.	M 915		

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: **01 - LAMAR HEALTHCARE & REHABILITATION CENTER** B. WING _____	**02/25/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAMAR HEALTHCARE & REHABILITATION CEI	**6428 US HIGHWAY 11 LUMBERTON, MS 39455**

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M1245	45.41.1 Date of Construction & Life Safety... Date of Construction and Life Safety Code Compliance. 1. Buildings constructed after the effective date of these regulations shall comply with the edition of the Life Safety Code (NFPA 101) effective on the date of construction. 2. Buildings constructed prior to the effective date of these regulations shall comply with Chapter 13 of the Life Safety Code (NFPA 101), 1985 edition. This Statute is not met as evidenced by: Based on observation and testing, the facility failed to provided a generator that transfer power to the facility within 10 seconds in accordance NFPA 110. This deficient practice has the potential to affect the entire facility on day of facility survey. Findings include: While testing the generator on 2-25-19 at 10:50 AM, observation revealed the generator failed to transfer power to the facility within 10 seconds. The generator transferred power to the facility in 14.28 seconds. The findings were acknowledged by the Administrator and the Maintenance Director verified this observation during the exit interview on 2-25-19.	M1245	1. Observation by surveyor revealed the generator failed to transfer power to the facility within 10 seconds. This was addressed by maintenance supervisor calling Contract Company to come and adjust time delays to shorten the time it takes to get the generator online. On 3/1/19 the generator passed the 10 second test. 2. All residents have the potential to be affected. 3. A Generator Check form has been developed and will be used weekly x 3 months to audit the start time of the generator. After 3 months, the generator will be checked monthly. Any changes to the testing of the generator will be approved by the Safety Committee and the Executive Director. 4. Any variance to the 10 second test will be reported to the Executive Director and QAPI team monthly.	3/1/19

Mississippi State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/15/19