

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/08/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255116	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/11/2021
NAME OF PROVIDER OR SUPPLIER LAKELAND NURSING AND REHABILITATION CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3680 LAKELAND LANE JACKSON, MS 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	
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was conducted by the State Agency (SA) on 03/08/21 through 03/11/21. The facility was found to be in compliance with infection control regulations and has implemented the Centers for Medicare and Medicaid (CMS) and the Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. The census was 89 and the facility has a license for 105 beds. The State Agency (SA) conducted complaint investigations (CI), CI MS 16580 for Quality of Care and Physical Environment, CI MS #16975 for Quality of Care, CI MS #17104 for Quality of Care concerns and Abuse/Neglect, CI MS #17107 for staffing concerns, CI MS #17254 for Abuse/Neglect, Quality of Care, Environmental, and Housekeeping concerns, CI CMS #17255 for Abuse/Neglect, Quality of Care concerns, CI MS #17506 for Dietary, Quality of Care and Administration concerns, and CI MS #17508 for Quality of Care and Abuse/Neglect concerns, from 03/08/21 through 03/11/21. During the survey, the SA did not substantiate the complaints. The census was 89 and the facility has a license for 105 beds.	F 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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