

MSDH - Health Facilities Licensure and Certification

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                   |                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>25LI</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>10/15/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>LAKELAND NURSING AND REHABILITATION CENTER</b> |                                                                                                                                                                                                                                                                                                                                             |                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>3680 LAKELAND LANE<br/>JACKSON, MS 39216</b>                                 |                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                      | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                    |
| {M 000}                                                                               | Initial Comments<br><br>The State Agency (SA) conducted a follow up/revisit survey on 10/15/21 for an annual and complaint survey completed from 8/9/21 through 8/13/21. The facility was in compliance with the Minimum Standards of Operation for Institutions for the Aged or Infirm and state licensure requirements effective 10/6/21. | {M 000}                                                                  |                                                                                                                          |                          |                                                                    |

Mississippi State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

10/20/21