STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255338	A. BUILDING _____ B. WING _____	06/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAMAR HEALTHCARE & REHABILITATION CENTER	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) COMPLETION DATE
F 000	INITIAL COMMENTS The State Survey Agency (SA) conducted an annual recertification survey at the facility from 05/30/2017 to 06/01/2017. During the survey the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation. The SA cited the regulatory deficiencies F278, F279, F280, F282, F314, and F441. At the time of the survey the census was 84, and the facility held a license for 120 beds.	F 000		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a	F 278		6/28/17

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

Electronically Signed | 06/28/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255338	A. BUILDING _____ B. WING _____	06/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAMAR HEALTHCARE & REHABILITATION CENTER	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) COMPLETION DATE
F 278	Continued From page 1 resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, facility policy review, and review of the Center for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Version 3.O Manual, revealed the facility failed to correctly code the Minimum Data Instrument (MDS) for Range of Motion (ROM) for three (3) of 17 resident assessments reviewed; Residents #2, #3, and #7. Findings include: A review of the Center for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Version 3.O Manual dated October 2016 in section Z0400 revealed the person who completes any section or portion of the MDS is required to sign the statement indicating that it is accurate. A review of the facility's policy titled, "Care Plans-Comprehensive", revised on 09/210, revealed: 4). Areas of concern that are triggered during the resident assessment are evaluated using specific assessment tools (including Care Area Assessments) before interventions are	F 278	*A SCPQ (significant correction to prior quarterly) was completed for resident #2 and for resident #7. These corrections were completed and submitted as required on 6/21/17. Resident #3 has discharged from the facility so a correction to the MDS in question was unable to be completed. *All residents who require an MDS assessment have the potential to be affected. *The MDS coordinator received an in-service on coding section G 0400B, section I and section M of the MDS per RAI guidelines. This education was provided on 6/21/17 by the facility nurse consultant. The IDT received an in-service regarding the necessity of completing each MDS section accurately per the RAI guidelines. This education was completed on 6/22/17 by the facility nurse consultant. Each interdisciplinary team member involved with completion of an MDS has access to an RAI manual to use as a reference as needed. An audit of residents residing in the facility will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255338	A. BUILDING _____ B. WING _____	06/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAMAR HEALTHCARE & REHABILITATION CENTER	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) COMPLETION DATE
F 278	Continued From page 2 added to the care plan. Resident #3 An observation, on 05/30/2017 at 10:05 AM, revealed a boot cast was on Resident #3's left leg. The boot cast reached from below the knee to the end of the toes. A review of Resident #3's History and Physical dated 03/19/2017, revealed the physical examination assessment relating to a diagnosis of a complete displacement of her left foot and ankle, and open dislocation and fracture of the tibia. A review of the Admission Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 04/05/2107, for Resident #3, revealed sections GO400B for Functional Limitation in Range of Motion (ROM) was coded a zero (0), thus indicating no left lower extremity impairment. Section I for Active Diagnoses I4000 for Other Fracture was coded as Unchecked, thus indicating no left lower extremity fracture. Section M for Skin Conditions M1040E for Other Skin Problems (Surgical Wound) was coded as Unchecked, thus indicated no repair of the left ankle fracture. During an interview, on 06/01/2017 at 10:00 AM, the Director of Nursing (DON), confirmed the MDS with an ARD date of 04/05/2017 for Resident #3 was not coded correctly. The DON stated the MDS for ROM of the lower extremities should be coded a one (1), thus indicating impairment to one (1) side, Active Diagnosis should be checked for a fracture, and there should be a check for a Surgical Wound. The	F 278	conducted to review for accurate coding of functional abilities, fracture diagnosis and surgical wounds. Corrections will be made following RAI guidelines based on results. This audit will be conducted by the Director of Nursing Services and completed on 6/28/17. *The Director of Nursing Services will review completed MDS's for accurate coding of ROM, Fracture Diagnosis and Surgical wounds. These audits will be completed weekly for three months. The results of these audits will be forwarded to the QAPI committee for review and further action as deemed necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255338	A. BUILDING _____ B. WING _____	06/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAMAR HEALTHCARE & REHABILITATION CENTER	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) COMPLETION DATE
F 278	Continued From page 3	F 278		

DON confirmed she was the person responsible for the updating of this MDS. The DON confirmed the facility used the Resident Assessment Manuel (RAI Manuel) for guidelines to complete the MDS.

Review of the facility's Face Sheet revealed the facility admitted Resident #3, on 08/20/2015, with diagnoses to include History of Falls, Abnormality of Gait Mobility, Syncope, and Collapse.

A review of the MDS with an ARD of 04/05/17, revealed Resident's #3's Brief Interview for Mental Status (BIMS) score was 14, which indicated the resident was cognitively intact.

Resident #2

Review of Resident #2's Admission Minimum Data Set (MDS), dated 02/09/2017, revealed the facility failed to code for range of motion impairment.

Review of the Comprehensive Care Plan, dated 2/28/17, revealed Resident #2 was at risk for falls related to a right hip fracture.

A review of the facility's Face Sheet revealed the facility admitted Resident #2 on 2/28/2017, with diagnoses which included Right Hip Fracture, Hypertension, Pressure Ulcer, Diabetes Mellitus, and Osteoarthritis.

A review of Resident #2's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/31/2017, revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 2, which indicated the resident was severely cognitively impaired.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255338	A. BUILDING _____ B. WING _____	06/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAMAR HEALTHCARE & REHABILITATION CENTER	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) COMPLETION DATE
F 278	Continued From page 4 Resident #7 Review of Resident #2's Minimum Data Set (MDS) dated 3/31/2017, revealed the facility failed to correctly code Resident #7's range of motion status. Review of the Comprehensive Care Plan, dated 6/3/13, revealed Resident #7 declined in self care related to residual from cerebrovascular accident with left sided weakness. Resident #7 was also weak due to renal failure/dialysis, and pain. The Care plan also revealed resident #7 required limited to extensive assist with transfers. During an interview, on 6/1/2017 at 9:50 AM, the Director of Nursing (DON) confirmed the facility failed to code range of motion correctly on Residents #2 and #7. A review of the facility's Face Sheet revealed the facility admitted Resident #7 on 8/18/08, and re-admitted the resident 3/3/2017,with diagnoses which included Right Hip Fracture, Hypertension, Diabetes Mellitus, Pressure Ulcer, and Osteoarthritis. A review of Resident #7's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 4/20/2017, revealed Resident #7 had a Brief Interview for Mental Status (BIMS) score of 2, which indicated the resident was severely cognitively impaired.	F 278		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident	F 279		6/28/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255338	A. BUILDING _____ B. WING _____	06/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAMAR HEALTHCARE & REHABILITATION CENTER	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) COMPLETION DATE
F 279	Continued From page 5 assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255338	A. BUILDING _____ B. WING _____	06/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAMAR HEALTHCARE & REHABILITATION CENTER	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) COMPLETION DATE
F 279	Continued From page 6 (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, facility policy review, and staff interview, the facility failed to develop a comprehensive care plan for Activities of Daily Living (ADLs) for two (2) of seventeen (17) resident care plans reviewed, Resident #3 and Resident #6. Findings include: During a review of the facility's policy titled, "Care Plans - Comprehensive", dated September 2010, it was revealed the comprehensive care plan is developed based on a thorough assessment. The facility policy stated that a comprehensive care plan is developed within seven (7) days of the completion of the comprehensive Minimum Data Set (MDS). The facility policy also states the comprehensive care plan is to aid in preventing or reducing a decline in the resident's functional status and/or functional levels. The	F 279	*The ADL care plan for residents #3 and #6 have been reviewed. Each care plan has been revised to address the specific problem and to include individualized interventions in order to address the ADL needs of each resident. This was completed by the MDS Coordinator on 6/22/17. *All residents who require assistance with ADL's have the potential to be affected. *The IDT members responsible for the development of care plans received an in-service on the development of patient-centered ADL care plans based on their individual assessment. This training was completed on 6/22/17 by the facility nurse consultant. An audit of care plans for all residents residing in the facility will be completed to review for the presence of a comprehensive ADL care plan. This	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255338	A. BUILDING _____ B. WING _____	06/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAMAR HEALTHCARE & REHABILITATION CENTER	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) COMPLETION DATE
F 279	Continued From page 7 comprehensive care plan is based on a thorough assessment that includes, but is not limited to, the Minimum Data Set (MDS). Resident #6 Review of Resident #6's Hospital Discharge Instructions, dated 03/014/2017, revealed the primary admitting diagnosis to the facility included but was not limited to a closed non-displaced oblique fracture of the shaft of the left femur. The discharge instructions, dated for 03/14/2017, also indicated that Resident #6 had a Non-Weight Bearing (NWB) status to the Left Lower Extremity (LLE). During a review of the Comprehensive Care Plan, dated 3/14/17 for Resident #6, it was revealed there was no documentation in the care plan for a non-displaced oblique fracture of the shaft of the left femur regarding the NWB status to the resident's LLE, and what the level or functional ADL assistance was needed for Resident #6. During an interview, and record review, on 06/01/2017 at 9:50 AM, with the Director of Nursing (DON), it was confirmed the facility had readmitted Resident #6, on 03/14/2017, with a primary admitting diagnosis to include a non-displaced oblique fracture to the left lower extremity identified as the femur. The DON confirmed Resident #6 was also admitted to the facility on 03/14/2017, with a NWB status to the LLE. The DON reviewed the comprehensive care plan for Resident #6 dated 03/14/2017, and confirmed there was no documentation on the care related to a LLE femur fracture, and a NWB status to the LLE. The DON stated Resident #6's ADL needs were not included on the	F 279	audit will be conducted by the MDS Coordinator, Medical Records Nurse and Director of Nursing Services and will be completed by 6/28/17. Based on the results of the audit, a corrective action will be taken and care plans will be developed or revised as needed. *Random care plan audits will be completed based on the MDS schedule to monitor for compliance with the presence of comprehensive ADL care plan which reflects the individualized needs of the resident. Three care plan reviews will be completed weekly for three months. These audits will be completed by the Director of Nursing. The results of these audits will be forwarded to the QAPI committee for review and additional action as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255338	A. BUILDING _____ B. WING _____	06/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAMAR HEALTHCARE & REHABILITATION CENTER	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) COMPLETION DATE
F 279	Continued From page 8	F 279		

comprehensive care plan. The DON stated Resident #6's care plan did not reflect the resident's ADL needs, and status.

A review of the Face Sheet revealed the facility admitted Resident #6 on 08/06/2013, and readmitted him on 03/14/2017, with diagnoses to include Non-displaced oblique fracture of the shaft of the left femur, and Dementia.

A review of the Medicare Part A-Thirty (30) Day/Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/23/2017, revealed the resident's Brief Interview for Mental Status (BIMS) score was 3, indicating severe impaired cognition.

Resident #3

Resident #3's May 2017 Physician's Orders revealed an order, dated 3/30/17, to admit the resident for Skilled Part A for a Fractured Ankle.

Review of Resident #3's Care Plan revealed the Problem/Need for High Risk for Falls was updated on 3/20/17 for a witnessed fall on 3/19/17, which resulted in a dislocation of the left ankle, and a fractured tibia. Further review of the care plan revealed no Approaches to monitor the soft cast and toes of the left lower leg for poor circulation, or other complications as ordered on 3/30/17.

Interview, on 06/1/2017 at 10:00 AM, with the Director of Nursing (DON) confirmed the monitoring of the soft cast and toes on the left leg for circulation, or other complications was not on the care plan for Resident #3. The DON also confirmed she and the MDS team are responsible

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255338	A. BUILDING _____ B. WING _____	06/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAMAR HEALTHCARE & REHABILITATION CENTER	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) COMPLETION DATE
F 279	Continued From page 9 for updating the care plans. Review of the facility's Face Sheet revealed the facility admitted Resident #3 on 08/20/2015, with diagnoses to include History of Falls, Abnormality of Gait Mobility, Syncope, and Collapse. A review of the MDS with an ARD of 04/05/17, revealed Resident's #3's Brief Interview for Mental Status (BIMS) score was 14, which indicated the resident was cognitively intact.	F 279		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care.	F 280		6/28/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255338	A. BUILDING _____ B. WING _____	06/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAMAR HEALTHCARE & REHABILITATION CENTER	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) COMPLETION DATE
F 280	Continued From page 10 (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255338	A. BUILDING _____ B. WING _____	06/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAMAR HEALTHCARE & REHABILITATION CENTER	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) COMPLETION DATE
F 280	Continued From page 11 medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to revise the care plan related to antibiotics and isolation, and target and goal dates for three (3) of 17 care plans reviewed, Resident #3, Resident #4, and Resident #6. Findings include: Review of the facility's policy titled, "Care Plans - Comprehensive", revised September 2010, revealed the assessments of residents would be ongoing and the care plans would be revised as information about the resident and the resident's condition changed. The policy also revealed the care planning/ interdisciplinary team would be responsible for the review, and updating the care plan when there is a significant change in the resident's condition, when the desired outcome is not met, and when the resident has been readmitted to the facility from a hospital stay, and at least quarterly. Resident #4	F 280	*The care plans for resident ##3, #4 and #6 have been reviewed and revised as needed to reflect their current status. This review was completed by the MDS Coordinator on 6/22/17. *All residents residing in the facility have the potential to be affected. *The IDT members involved in the assessment process received an in-service on the development, initiation and revision of care plans on 6/22/17 by the facility nurse consultant. An audit of residents residing in the facility requiring isolation and or receiving antibiotics has been conducted to monitor for the presence of a care plan. The review was completed by the MDS coordinator on 6/22/17. Corrective action was taken based on results of the audit. An audit of the care plans for residents residing in the facility will be conducted to review that goals and target dates have been updated. This review will be conducted by the MDS Coordinator, Medical Records	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255338	A. BUILDING _____ B. WING _____	06/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAMAR HEALTHCARE & REHABILITATION CENTER	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) COMPLETION DATE
F 280	Continued From page 12 A review of Resident #4's current comprehensive Care Plan revealed no documentation of the resident's return from the hospital on 05/11/17, documentation of a diagnosis of Clostridium difficile (C-diff), and contact isolation on 05/12/17. The Goal and Target Dates for 19 of 20 of Resident #4's comprehensive Care Plan's Problems/Needs was documented 04/10/17. One problem for discharge planning was dated 7/15/17. A review of Resident #4's Physician Orders revealed an order for Vancomycin capsule for the diagnosis of C-diff, and contact isolation on 05/12/17. Resident #4 had a Physician's Order to discontinue the contact isolation on 05/26/17. A review of Resident #4's Nurse's Notes revealed the resident was on contact precautions on 05/24/17, and an order to discontinue contact precautions on 05/26/17. An interview on 06/01/17 at 10:30 AM, with Director of Nursing (DON), revealed she confirmed the target date for Resident #4's current comprehensive care plan was 04/10/17. The DON said she did not know why the date on the care plan was not updated, but it should be adjusted at least quarterly. The DON also confirmed the care plan should have addressed Resident #4's contact isolation precautions, and antibiotic therapy. A review of the facility's Face Sheet revealed the facility admitted Resident #4 on 10/10/16. Resident #4's diagnoses included Clostridium Difficile, and Respiratory Failure. The Minimum Data Set (MDS) with an Assessment Reference	F 280	Nurse and Director of Nursing Services and will be completed by 6/28/17. Corrective action will be taken as needed based on results of the audit. *Residents receiving antibiotics and or requiring isolation will be reviewed 5 days a week by the IDT. Care plans will be reviewed and revised as needed. Three care plan reviews will be completed weekly for three months to monitor for revision of goal land target dates. These reviews will be completed by the MDS Coordinator and Medical Records Nurse. The results of these audits will be forwarded to the QAPI committee for review and additional action as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255338	A. BUILDING _____ B. WING _____	06/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAMAR HEALTHCARE & REHABILITATION CENTER	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) COMPLETION DATE
F 280	Continued From page 13	F 280		

Date (ARD) of 03/28/17, revealed Resident 4's Brief Interview for Mental Status (BIMS) score was 13, which indicated intact cognition.

Resident #6

During a review of the Comprehensive Care Plan for Resident #6, it was revealed the Target/Goal dates for nine (9) out of ten (10) identified problem areas were past the documented timetable. One (1) problem identified had a Target/Goal date of 05/15/2017, one (1) problem identified had a Target/Goal date of 05/17/2017, and seven (7) problems identified had a Target/Goal date of 05/21/2017.

During an interview on 06/01/2017 at 9:50 AM, with the Director of Nursing (DON), it was confirmed the facility had readmitted Resident #6, on 03/14/2017, with a primary admitting diagnosis to include a nondisclosed oblique fracture to the left lower extremity identified as the femur. The DON confirmed all the target/goal dates, with the exception of one (1), had expired. The DON confirmed the care plan should have been updated with new target/goal dates.

A review of the Face Sheet revealed the facility admitted Resident #6 on 08/06/2013, and readmitted him on 03/14/2017, with a diagnosis to include Non-displaced oblique fracture of the shaft of the left femur, and Dementia.

A review of the Medicare Part A-Thirty (30) Day/ Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/23/2017, revealed the resident's Brief Interview for Mental Status (BIMS) score was 3, indicating severely impaired cognition.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255338	A. BUILDING _____ B. WING _____	06/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAMAR HEALTHCARE & REHABILITATION CENTER	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) COMPLETION DATE
F 280	Continued From page 14 Resident #3 A review of Resident # 3's Care Plan revealed the most recent Goal/Target dates were 08/22/2016, and 04/06/2017. An interview on 06/01/2017 at 10:30 AM, with the Director of Nurse (DON), revealed the comprehensive Care Plan for Resident #3 was not revised, and should have been revised to include new target dates after the update of the Minimum Data Sheet (MDS) that was dated for 4/05/2017. The DON confirmed she was the Registered Nurse (RN) who had signed off on this MDS. Review of the facility's Face Sheet revealed the facility admitted Resident #3 on 08/20/2015, with diagnoses to include History of Falls, Abnormality of Gait Mobility, Syncope and Collapse. A review of the MDS with an ARD of 04/05/17, revealed Resident #3's Brief Interview for Mental Status (BIMS) score was 14, which indicated the resident was cognitively intact.	F 280		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced	F 282		6/28/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255338	A. BUILDING _____ B. WING _____	06/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAMAR HEALTHCARE & REHABILITATION CENTER	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) COMPLETION DATE
F 282	Continued From page 15 by: Based on observation , staff interview, record review, and facility policy review, the facility failed to ensure Resident #2's care plan was followed related to wound care for (1) of (17) care plans reviewed. Findings include: A Review of the facility's policy titled, "Care Plan", dated September 2010, revealed an individualized Comprehensive care plan includes measurable objectives and timetables to meet the resident's medical, nursing, mental, and psychological needs is developed for each resident. A review of Resident #2's comprehensive Care Plan, dated 2/28/2017, revealed Resident #2 was at risk for impaired skin integrity related to decreased mobility, aged skin, poor nutrition, and multiple wounds with an intervention to follow the treatment as ordered. An observation of incontinent care, on 5/31/2017 at 2:30 PM, with The Director of Nursing (DON), and Certified Nursing Aide (CNA) #2, revealed Resident #2 did not have a bandage on an unstageable wound to the buttocks. The wound was covered with feces. An interview with Certified Nurse Aide (CNA) #2, on 5/31/2017 at 3:00 PM, confirmed the CNA failed to notify the nurse Resident #2 did not have a bandage on his unstageable wound. CNA #2 stated she forgot to tell the nurse when she changed Resident #2's brief that morning. An interview with the DON, on 5/31/2017 at 3:00	F 282	*The Director of Nursing assessed the pressure ulcer on May 31, 2017 on Resident #2 and no signs and/or symptoms of infection were noted to the wound. The prescribed treatment was performed and dressing was applied to Resident #2's pressure wound on May 31, 2017 by the Licensed Practical Nurse. Resident #2 no longer resides at the facility as he discharged on June 6, 2017. *Residents requiring wound care have the potential to be affected. *Licensed nurses and nursing assistants will receive in-service training regarding following care plan interventions related to wound care. This education will be conducted by the Director of Nursing Services and RN supervisor and will be completed by 6/28/17. *Random observations of residents with care plan interventions pertaining to wound care will be completed to monitor for compliance. An observation of one resident with orders for a bandage related to a wound will be completed on a weekly basis for a period of three months. These observations will be completed by the treatment nurse. The results of these observations will be forwarded to the QAPI committee for review and additional action as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255338	A. BUILDING _____ B. WING _____	06/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAMAR HEALTHCARE & REHABILITATION CENTER	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) COMPLETION DATE
F 282	Continued From page 16 PM, confirmed the facility failed to assure a bandage was on an unstageable wound to the buttocks. The DON said the CNAs are trained to notify the nurse when bandages are soiled, or come off the wounds. Review of the Face Sheet revealed the facility admitted Resident #2 on 02/28/2017, with diagnoses which included Right Hip Fracture, Pressure Ulcer, Hypertension, Osteoarthritis and Diabetes Mellitus. A review of the current quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 04/20/2017, revealed Resident #2 scored 2 on the Brief Interview of Mental Status (BIMS), which indicated severe cognitive impairment.	F 282		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.	F 314		6/28/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255338	A. BUILDING _____ B. WING _____	06/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAMAR HEALTHCARE & REHABILITATION CENTER	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) COMPLETION DATE
F 314	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to assure a bandage was on an unstageable wound to the buttocks for (1) of (5) care observations, for Resident #2. Findings include: An observation of wound and incontinent care, on 5/31/2017 at 2:30 PM, with the Director of Nursing (DON) and Certified Nursing Aide (CNA) #2, revealed Resident #2 did not have a bandage on an unstageable wound to the buttocks. The wound measured 5.5 centimeters (cm) by 5 cm by 0.5 cm, and was covered with 90% yellow slough. The exposed wound was covered with brown feces. A review of the facility's Physicians Orders, dated May 2017, revealed an order to cleanse the buttocks with wound cleanser, pat dry, apply santyl topically to wound bed, cover with foam dressing daily and prn (as needed). During an interview with Certified Nurse Aide (CNA) #2, on 5/31/2017 at 3:00 PM, she revealed she failed to notify the nurse Resident #2 did not have a bandage on his unstageable wound. CNA #2 stated she forgot to tell the nurse when she changed Resident #2's brief earlier that morning. CNA #2 also said the wound was covered with feces during the morning change. An interview with the DON, on 5/31/2017 at 3:00 PM, confirmed the facility failed to assure a bandage was on an unstageable wound to the buttocks. The DON said the CNAs are trained to notify the nurse when bandages are soiled, or	F 314	*The Director of Nursing assessed the pressure ulcer on May 31, 2017 on Resident #2 and no signs and/or symptoms of infection were noted to the wound. The prescribed treatment was performed and dressing was applied to Resident #2's pressure wound on May 31, 2017 by the Licensed Practical Nurse. Resident #2 no longer resides at the facility as he discharged on June 6, 2017. *Residents requiring wound care have the potential to be affected. *CNA #2 has received education on the need to notify the licensed nurse when a bandage is not in place as ordered. This education was completed on 6/23/17 by the Director of Nursing Services. Licensed nurses and nursing assistants will receive in-service training regarding notification to the appropriate staff member when an ordered bandage is observed to not be in place. This training will be conducted by the Director of Nursing Services and RN supervisor and will be completed by 6/28/17. *Random observations of residents with orders for bandage related to wound care will be completed to monitor for compliance. An observation of one resident will be completed on a weekly basis for a period of three months. These observations will be completed by the Treatment Nurse. The results of these observations will be forwarded to the QAPI committee for review and additional action as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255338	A. BUILDING _____ B. WING _____	06/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAMAR HEALTHCARE & REHABILITATION CENTER	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) COMPLETION DATE
F 314	Continued From page 18 come off the wounds. The DON also said the wound nurse called in, and was unavailable for an interview. A review of the facility's Face Sheet revealed the facility admitted Resident #2 on 2/28/2017, with diagnoses which included Right Hip Fracture, Hypertension, Diabetes Mellitus, Osteoarthritis, Mental Illness, and Pressure Ulcer. A review of Resident #2's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 4/20/2017, revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 2, which indicated the resident was severely cognitively impaired.	F 314		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F 441		6/28/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255338	A. BUILDING _____ B. WING _____	06/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAMAR HEALTHCARE & REHABILITATION CENTER	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) COMPLETION DATE
F 441	Continued From page 19 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255338	A. BUILDING _____ B. WING _____	06/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAMAR HEALTHCARE & REHABILITATION CENTER	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) COMPLETION DATE
F 441	Continued From page 20 spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to discard biohazard material in the appropriate container, and to prevent the possible spread of infection by failing to cover a sacral wound with a dressing for two of five (2) of (5) resident care observations, for Resident #1 and Resident #2. Findings include: A review of the facility's policy titled, "Infection Control Guidelines For All Nursing Procedures",, dated August 2012, revealed the purpose is to provide guidelines for general infection control while caring for residents. The preparation prior to having direct-care responsibilities for residents, staff must have appropriate in-service training on managing infections in resident care, including: types of Healthcare-associate infections, methods of preventing their spread, how to recognize and report signs and symptoms of infection and prevention of transmission of multi-drug resistant organisms. Review of the facility's policy titled, "Dressings, Soiled/Contaminated", revised August 2009, revealed soiled dressings that were heavily soiled with exudates or drainage must be placed in specially designated biohazard containers for disposal. Resident #2	F 441	*The Director of Nursing assessed the pressure ulcer on May 31, 2017 on Resident #2 and no signs and/or symptoms of infection were noted to the wound. The prescribed treatment was performed and dressing was applied to Resident #2's pressure wound on May 31, 2017 by the Licensed Practical Nurse. Resident #2 no longer resides at the facility as he discharged on June 6, 2017. No corrective action for resident #1 is required. *Residents residing in the facility have the potential to be affected. *CNA #2 has been educated on the need to notify the licensed nurse when a bandage is not in place as ordered. This education was completed on 6/23/17 by the Director of Nursing. Education regarding the Biohazards waste policy was conducted with CNA #1. This education was completed on 6/23/17 by the Director of Nursing. Licensed nurses and nursing assistants will receive in-service training regarding notification to the appropriate staff member when an ordered bandage is observed to not be in place. Additionally they will receive training regarding the Biohazards Waste policy. This training will be conducted by the Director of nursing and RN supervisor and will be completed by 6/28/17.Random	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255338	A. BUILDING _____ B. WING _____	06/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAMAR HEALTHCARE & REHABILITATION CENTER	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) COMPLETION DATE
F 441	Continued From page 21 An Observation of wound and incontinent care, on 5/31/2017 at 2:30 PM, with the Director of Nursing (DON) and Certified Nursing Aide (CNA) #2, revealed Resident #2 did not have a bandage on an unstageable wound on the buttocks. The wound was covered with brown feces. An interview, on 5/31/17 at 3:00 PM, with Certified Nurse Aide (CNA) #2 revealed she failed to prevent the possible spread of infection as evidenced by failure to notify the nurse there was no bandage was on the resident's unstageable wound. CNA #2 stated she forgot to tell the nurse when she changed Resident #2's brief that morning the bandage was off. CNA #2 confirmed the wound was covered with feces during the morning incontinent care. During an interview with the Director of Nursing (DON), on 5/31/2017 at 3:00 PM, she confirmed the facility failed to prevent the possible spread of infection as evidenced by no bandage was maintained on the resident's wound, allowing fecal contamination. A review of the facility's Face Sheet revealed the facility admitted Resident #2 on 2/28/2017, with diagnoses including Right Hip Fracture, Hypertension, Diabetes Mellitus, Pressure Ulcer, and Osteoarthritis. A review of Resident #2's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 4/20/2017, revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 2, which indicated the resident was severely cognitively impaired.	F 441	observations of residents with orders for a bandage related to a wound will be completed to monitor for compliance. An observation of one resident will be completed on a weekly basis for a period of three months. These observations will be completed by the treatment nurse. The results of these observations will be forwarded to the QAPI committee for review and additional action as needed. *Random interviews will be conducted with nursing assistants and licensed nurses regarding the appropriate disposal of bandages that may be contaminated with biohazard waste to monitor for compliance with this policy. Two staff members will be interviewed weekly for three months. These interviews will be conducted by Assistant Director of Nursing. The results of these interviews will be submitted to the QAPI committee for review and any additional follow-up needed based on results.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255338	A. BUILDING _____ B. WING _____	06/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAMAR HEALTHCARE & REHABILITATION CENTER	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) COMPLETION DATE
F 441	Continued From page 22 Resident #1 An observation, on 05/31/17 at 3:00 PM, revealed Certified Nursing Assistant (CNA) # 1 had removed the old wound dressing from Resident #1's coccyx during incontinent care. The old dressing was only secured on one side, and was observed to have thick, brown exudates on the inside of the dressing. CNA #1 placed the old wound dressing into the clear garbage bag with her gloves and perineal wipes. CNA #1 then walked with the garbage bag to the shower room, and placed the bag into a regular garbage can. An interview, on 05/31/17 at 4:20 PM, revealed CNA #1 confirmed she had placed the soiled wound dressing into the regular garbage in the shower room. CNA #1 stated the dressing was not clean, and was covered in a brown, thick substance on the inside. An interview, on 05/31/17 at 4:20 PM, revealed the Director of Nursing (DON) said the policy of the facility about soiled dressings with blood products should be placed into the biohazard room. The DON pointed to the room with the biohazard sign beside the shower room, and said the concern was possible blood contamination. A review of Resident #1's Treatment Record revealed an order to cover with foam dressing for a Stage II pressure ulcer to the coccyx every day. A review of a document titled, "Infection Control/Standard Precautions", dated 10/21/15, revealed CNA #1 completed the training. No further inservices were provided by the facility that CNA #1 had attended in 2016 or 2017.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255338	A. BUILDING _____ B. WING _____	06/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAMAR HEALTHCARE & REHABILITATION CENTER	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) COMPLETION DATE
F 441	Continued From page 23 A review of the facility's Face Sheet revealed the facility admitted Resident #1 on 05/02/14. Resident #1's diagnoses included Stage II Pressure Ulcer, and Paraplegia. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/03/17, revealed Resident #1's Brief Interview for Mental Status (BIMS) score was six (6), which indicated moderate impaired cognition.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255338	A. BUILDING **01 - LAMAR HEALTHCARE & REHABILITATION CENTER** B. WING _____	**06/01/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAMAR HEALTHCARE & REHABILITATION CENTER	**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) COMPLETION DATE
K 000	INITIAL COMMENTS 42 CFR 438.70(a) The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 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.