

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

PRINTED: 08/09/2022  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                            |                                                                                                                          |                            |                                                                    |
|-----------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255338</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>07/05/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>LAMAR HEALTHCARE &amp; REHABILITATION CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6428 US HIGHWAY 11</b><br><b>LUMBERTON, MS 39455</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>COMPLETION<br>DATE |                                                                    |
| F 000                                                                                   | <p>INITIAL COMMENTS</p> <p>The State Agency (SA) conducted a Complaint Investigation (CI), MS #18972 at the facility on 7/05/22. The SA did not substantiate the complaint for Resident Neglect, Accidents, Nursing Services, or Quality of Care/Treatment and there were no deficiencies cited. The facility remains out of compliance with Medicare and Medicaid participation requirements due to deficiencies cited on the May 19, 2022 Annual Recertification survey.</p> <p>The facility held a license for 120 beds, with a census of 57.</p> | F 000                                                                      |                                                                                                                          |                            |                                                                    |

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

TITLE

(X6) DATE

Electronically Signed

07/21/2022

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.