

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25LI	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/16/2023
NAME OF PROVIDER OR SUPPLIER LAKELAND NURSING AND REHABILITATION CENTER		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) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted a Complaint Investigation (CI) at the facility for two (2) complaints, CI MS #21102 and CI MS #21415 from 5/15/23 through 5/16/23. During the survey, the SA determined the facility was in compliance with the Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm. The SA investigated MS #21102 for Quality of Care/Treatment related to timing of resident medications and resident abuse and MS #21415 for Quality of Care/Treatment related to answering the call bell, incontinent care and Accidents related to an unwitnessed fall and no deficiencies were cited.	M 000		

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

05/30/23