STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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LAKELAND NURSING AND REHABILITATION CENTEI	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 an annual recertification survey and Complaint Investigation (CI), MS #22398, at the facility from 09/12/23 through 9/14/23. The SA investigated MS #22398 related to facility staffing, call bell not answered in a timely manner, care not received per physician orders, dietary services, resident rights related to resident not being treated with dignity and respect, and physical environment related to offensive odors in the facility, and cited M500. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirement and cited M500 related to restraints, M655 related to oxygen tubing and M1570 related to infection control.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate;	M 500		10/20/23

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M 500	Continued From page 1 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff	M 500		

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M 500	Continued From page 2	M 500		

and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal;

6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law;

7. is free from mental and physical abuse;
8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint;
9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract;

10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;

11. is not required to perform services for the facility that are not included for therapeutic

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M 500	Continued From page 3 purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights.	M 500		

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M 500	Continued From page 4 This Statute is not met as evidenced by: Level II Based on observations, interviews, record review, and facility policy review, the facility failed to ensure residents were provided an environment free of urine odors and ensure a resident was without physical restraints related to the use of full-length bed rails for two (2) of three (3) days of survey. Findings include: A review of the facility document, "Resident Bill of Rights", dated 01/2023, revealed, "Each resident has a right to a dignified existence ...in an environment that promotes maintenance or enhancement of (his or her) quality of life ...A. Facility residents shall have the right to ...32. A safe clean, comfortable home like environment..." An observation of the Central and North halls, on 09/12/23 at 10:05 AM, revealed there was a strong urine odor along both hallways. An observation of the Central and North hallways, on 09/12/23 at 01:30 PM, revealed both hallways had a strong urine odor. An observation, on 09/13/23 at 09:32 AM, revealed the Central and North hallways had a urine odor. On 9/14/23 at 9:10 AM, an observation of the North Hall and Central Hall biohazard rooms revealed strong urine odors coming from the rooms. The barrels were full but covered. No debris was observed on the floor.	M 500	No Residents had any ill effects from this deficient practice. North Hall and Central Hall biohazard rooms were cleaned on 9/13/2023 by housekeeping supervisor to include disposing of garbage and ensuring that a lid was present for the containers. All Residents who reside on North Hall and Central Hall have the potential to be affected from the odors from the biohazard rooms. An in-service was initiated by Staff Development on 9/13/2023 for housekeeping and nursing staff on ensuring that the containers in the biohazards rooms on North Hall and Central Hall were emptied timely and to lids are present to ensure that the provide an environment free of urine odors. The Executive Director and/or Housekeeping Supervisor will make rounds 2 times pers day x 5 days x 4 weeks then weekly x 2 weeks starting 09/15/23 to ensure that the biohazard rooms on North Hall and Central Hall are free of odors, containers are emptied frequently and lids are present on the containers. Any concerns will be immediately addressed. The results of the audits will be forwarded to the monthly Quality Assurance Committee by the Executive Director starting 10.06.2023 and reviewed in November Quality Assurance Committee. The Quality Assurance	

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M 500	Continued From page 5 An interview with Licensed Practical Nurse (LPN) #1, on 09/12/23 at 11:00 AM, confirmed there was a strong urine odor in the Central and North hallways. She revealed she felt the odors came from the buildup of trash and laundry in the biohazard room located on each hall. LPN #1 reported she smelled the odor mainly at 6:30 AM, because the overnight shift Certified Nurse Aides (CNAs) allow the trash and laundry to build up. On 9/14/23 at 8:37 AM, with two (2) Unsampled Residents in the hallway, revealed the residents smelled the odors along the Central and North hallway. The residents grimaced as they reported smelling the strong urine odors. In an interview with the Housekeeping Supervisor (HS) on 09/14/23 at 08:44 AM, he stated that he believed the odor along the hallways was caused by trash build up in the biohazard rooms that are located on each hall. The HS reported soiled laundry and trash are stored in the biohazard rooms. The facility's housekeeping staff remove the soiled laundry from the biohazard rooms hourly and take it to the laundry The CNAs are responsible for removing the trash as the barrels are filled and disposing it in the facility dumpster. An interview with CNA #4 on 09/14/23 at 09:23 AM, revealed he noticed the odors in the hallways when the laundry and trash built up in the biohazard rooms. CNA #4 reported he removed the trash from the biohazard rooms as needed, on the days that he works. CNA #4 also reported the CNAs checked the trash in the biohazard rooms every 2 hours to see if it needed to go out to the dumpster. On 09/14/23 at 01:30 PM, an interview with the	M 500	Committee will make recommendations for continuation of audits, frequency or discontinuation based upon the results achieved.	

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M 500	Continued From page 6 Administrator confirmed she had noticed strong urine odors on and off in the year and a half that she has worked at the facility. The Administrator reported she typically noticed the strong odors around 2:00 PM and acknowledged the unpleasantness for Residents who live in the facility and must smell the strong odor of urine throughout the day. Restraints: Based on observations, interviews, record review, and facility policy review, the facility failed to ensure a resident was without physical restraints related to the use of full-length bed rails for one (1) of 21 sampled residents. Resident #22 Findings include: A review of the facility document, "Resident Bill of Rights", dated 01/2023, revealed, "Each resident has a right to a dignified existence ...in an environment that promotes maintenance or enhancement of (his or her) quality of life ...A. Facility residents shall have the right to ...37. be free of physical ...restraints ..." A record review of the facility's policy "Restraint Evaluation and Restraint Reduction", dated 8/2013 revealed " ... all residents have the right to be unrestrained. Restraints should be used only as a last alternative and only when other less restrictive measures have been tried and rejected ...Definition: 'Physical restraints' are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body ... Procedure: ... 1. The following devices are	M 500		

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M 500	Continued From page 7 considered physical restraints and require evaluation ...Side rails that restrict freedom of movement and cannot be easily removed are considered a restraint ...2. All residents using a restraint are to be evaluated and re-evaluated approximately every quarter ...4. A specific physician's order is to be entered in the resident's Medical Record which details the medical reason, type of restraint and when to be used ... " On 09/12/23 at 12:12 PM, during an observation, Resident # 22 was lying in bed and had two (2) full length side rails that were raised. On 09/13/23 at 10:00 AM, 12:08 PM and 04:15 PM, Resident #22 was lying in bed with two (2) full length bed rails that were raised. Record review of the "Face Sheet" revealed the facility admitted Resident #22 on 05/14/14 with diagnoses that included Unspecified Dementia. Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/5/23 revealed Resident #22 had a staff interview which indicated she had short and long term memory problems and her cognitive skills for daily decision making was severely impaired. Review of the medical record revealed there was no Physician's Order for full-length bed rails, no documentation of the facility attempting a lesser restrictive alternative, no documentation of ongoing re-evaluation of the need for the restraint, no documentation that the bed rails had been evaluated for entrapment issues, and there was no informed consent signed by the Resident or the Resident Representative for the use of full-length bed rails.	M 500		

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M 500	Continued From page 8 On 09/12/23 at 04:00 PM, during an interview with the Director of Nursing (DON), she revealed Resident # 22's original bed had recently broken and since he was on hospice services, the hospice company brought a new one to the facility for the resident to use. The DON stated that she was aware that Resident #22 had a bed with two (2) full length bed rails, but she did not think that would be a restraint since the resident was unable to get out of the bed. She also confirmed there was no Physicians' Order in the resident's record for the full-length bed rails.	M 500		
M 655	45.21.11 Special needs Special needs. Each resident with special needs shall receive proper treatment and care. These special needs shall include, but are not limited to injections; parenteral and enteral fluids; colostomy, ureterostomy, ileostomy care; tracheostomy care; tracheal suction; respiratory care; foot care; and prostheses. This Statute is not met as evidenced by: Level II Based on observation, interviews, record review, and the facility policy review the facility failed to provide respiratory services in a manner to prevent the possibility of complications for two (2) of two (2) residents reviewed for respiratory conditions. Resident #3 and Resident #15. Findings include: A record review of the facility's policy, "Standard Precautions", dated 09/2019, revealed, "	M 655	Resident # 3 Continuous positive airway pressure machine tubing was replaced on 9.13.2023 by Charge Nurse. Resident # 15 O2 tubing was replaced on 9.12.2023 by Charge Nurse. Resident # 3 and # 15 had no ill effects from this deficient practice. Resident #3 assessed by Director of Nursing on 9.13.2023. Resident #15 was assessed by Director of Nursing on 9.12.23 All Residents who require respiratory services have the potential to be affected.	10/20/23

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M 655	Continued From page 9 ...Procedure ...5. Handle soiled patient care equipment in a manner that prevents transfer of microorganisms to others and to the environment ..." Resident #3 On 09/12/23 at 9:00 AM, during an observation, Resident #3 had a Continuous Positive Airway Pressure (CPAP) device in his room and the tubing was on the floor of the room. There was no bag or designated container to store the tubing. On 09/12/23 at 11:50 AM, in an observation of Resident #3, his CPAP tubing remained on the floor on the right side of bed. There was a face mask for the CPAP located in a plastic bag on the resident's windowsill in his room. On 09/13/23 at 08:30 AM, in an observation of Resident #3, he was lying in bed and the CPAP tubing was on the floor of his room. On 09/13/23 at 08:36 AM, an interview and observation of Resident #3 with Licensed Practical Nurse #1 (LPN) revealed the CPAP tubing was on the floor in the resident's room. LPN #1 stated the tubing should not be on the floor because it could cause the resident to get an infection. LPN #1 retrieved the tubing from the floor and placed it on the windowsill by the CPAP machine and exited the room. On 09/14/23 at 10:34 AM, in an interview with the Director of Nursing (DON), who is also the Infection Preventionist (IP), she stated LPN #1 should have discarded the tubing that had been on the floor. She confirmed that the CPAP tubing should be stored in a plastic bag to prevent	M 655	A 100% audit was completed on 9.13.2023 by Unit Managers to ensure that all respiratory tubing was placed in plastic bags and any tubing found on the floor was immediately discarded and replaced. An in-service was initiated by Staff Development for nursing staff on ensuring that respiratory services are provided in a manner to prevent the possibility of complications by bagging O2 tubing and replacing tubing that becomes in contact with the floor. The Director of Nurses and/or Unit Manager will make rounds beginning 9.18.2023 5x week x 4 weeks then 2 x week x 2 weeks to ensure that respiratory tubing is bagged and not on the floor. Any concerns will be immediately addressed. The results of the audits will be forwarded to the monthly Quality Assurance Committee begining on 10.06.23 and reviewed with November Quality Assurance Committee. The Quality Assurance Committee will make recommendations for continuation of audits, frequency or discontinuation based upon the results achieved.	

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M 655	Continued From page 10	M 655		

contamination and to prevent possible complications, such as an upper respiratory infection.

A record review of the "Face Sheet" revealed the facility admitted Resident #3 on 6/3/2020 with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD) and Chronic respiratory failure, unsp (unspecified) with hypoxia or hypercapnia.

A record review of the "Physician's Telephone Order", dated 7/5/23 revealed a Physician's Order for "Place C-PAP on with full face mask ..."

A record review of the "Infection Control Orientation Check List", dated 7/11/23, revealed LPN #1 received training on Infection Control.

Resident #15

On 09/12/23 at 09:55 AM, during an observation and interview, Certified Nursing Assistant (CNA) #1 retrieved Resident #15's Oxygen (O2) tubing with a Nasal Cannula (NC) from the floor and placed it on the resident's bed. She then took the same O2 tubing she retrieved from the floor and placed the prongs of the NC inside the resident's nose. CNA #1 then removed the NC from the resident and used a wet washcloth with soap and water to clean the tubing and replaced the NC back into the resident's nose. CNA #1 confirmed the O2 tubing had been on the floor and that she should have cleaned it before putting it on the resident because it could have caused the resident to get an infection.

On 09/14/23 at 10:36 AM, in an interview with the DON, she stated that CNA #1 should have notified the nurse to discard the dirty tubing and

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M 655	Continued From page 11 apply new O2 tubing. The DON confirmed that CNA #1 should not have cleaned the O2 tubing and NC with soap and water and placed it back in the resident's nose. A record review of the "Face Sheet" revealed the facility admitted Resident #15 on 3/9/2021 with diagnoses that included Pneumonia. A record review of the "Physician Orders" for the month of September 2023, revealed a Physician's Order, dated 3/15/22 for "Continuous Oxygen at 2L (Liters) per NBP (Nasal Bi-Prong)." A record review of the "Infection Control Orientation Check List", dated 1/30/23, revealed CNA #1 received training on Infection Control.	M 655		
M1570	48.58.1 Infection Control The following infection control standards shall be met: 1. The facility must maintain and document an effective infection control program that protects patients, families, visitors, and facility personnel by preventing and controlling infections and communicable diseases. 2. The facility must have an active surveillance program that includes specific measures for prevention, early detection, control, education, and investigation of infections and communicable diseases in the facility. There must be a mechanism to evaluate the effectiveness of the program(s) and take corrective action when necessary. The program must include implementation of nationally recognized systems of infection control guidelines to avoid sources	M1570		10/20/23

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M1570	Continued From page 12 and transmission of infections and communicable diseases. 3. The facility must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions. This Statute is not met as evidenced by: Level II Based on observations, interviews, record reviews, and the facility policy review the facility failed to prevent the possibility spread of infections by placing soiled dressings in the resident's trash for (1) out of 21 sampled residents. Resident #11 Findings include: Review of the facility's "Standard Precautions" policy, dated 09/2019, revealed, " ...Standard Precautions will be utilized to provide a primary strategy for the prevention of healthcare-associated (HAI) agents among patients and healthcare personnel ...Procedure ...10. Follow procedures for disposal of regulated/infections waste when items are saturated with blood ..." On 09/13/23 at 03:07 PM, in an observation and interview with Licensed Practical Nurse (LPN) #2 she performed wound care on Resident #11 with the assistance of Registered Nurse #2/Nurse Manager. LPN #2 removed the soiled dressings from the wounds to the buttocks and sacrum and discarded the bloody dressings in a clear bag in the resident's garbage can. During the interview, LPN #2 confirmed that placing soiled dressings in the resident's garbage, and not in red biohazard	M1570	The garbage bag that LPN# 1 discarded the wound dressing was immediately removed by LPN on 9.13.2023. Resident # 11 had no ill effects from this deficient practice. Resident #11 assessed by Director of Nursing on 9.13.23. All Residents who require dressing changes have the potential to be affected. An in-service was initiated on 9.13.2023 by Staff Development to prevent the spread of infections by placing soiled dressings in the Residents' rooms trash bags to include soiled dressings should be placed in red biohazard bags and placed in the red biohazard barrel. The Director of Nursing and/or Unit Manager will make rounds beginning 9.18.2023 5 x week x 4 weeks then 2 x weeks x 2 weeks to ensure soiled dressings are not being placed in Residents' room garbage cans and being discarded properly by placing in red biohazard bags and placed in the red biohazard barrels. Any concerns will be immediately addressed. The results of the audits will be forwarded to the monthly Quality Assurance Committee beginning 10.06.23 then reviewed in November	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25LI	A. BUILDING: _____ B. WING _____	09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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M1570	Continued From page 13 bags, was a possible infection control issue. On 09/13/23 at 03:30 PM, an interview with RN #2, revealed that the medical waste should never be placed in the regular garbage. She confirmed that soiled dressings should always be placed in a red biohazard bag and put in a red biohazard barrel to prevent the possible spread of infection. On 9/13/23 at 3:50 PM, an interview with the Director of Nursing (DON), revealed that LPN #2 should have followed infection control protocols when dealing with blood or bodily fluids and should have disposed of those items in the designated red biohazard bags. Record review of the "Face Sheet" revealed the facility admitted Resident #11 on 1/09/2018 with diagnoses that included Parkinson ' s Disease. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/2/23 revealed Resident #11 had a Brief Interview for Mental Status (BIMS) score of 12 which indicated her cognition was moderately impaired.	M1570	Quality Assurance Committee. The Quality Assurance Committee will make recommendations for continuation of audits, frequency or discontinuation based upon the results achieved.	