STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255116	A. BUILDING _____ B. WING _____	09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND NURSING AND REHABILITATION CENTER LLC	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) COMPLETION DATE
F 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 F584. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F604, F695, and F880. The facility held a license for 105 and had a census of 91.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss	F 584		10/20/23

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

Electronically Signed | 09/28/2023

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F 584	Continued From page 1 or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and facility policy review, the facility failed to provide an environment free of urine odor for two (2) of three (3) facility halls. Central Hall and North Hall. 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..."	F 584	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.	

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F 584	Continued From page 2 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. 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	F 584	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 per 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 then with Novemeber Quality Assurance Meeting. The Quality Assurance Committee will make recommendations for continuation of audits, frequency or discontinuation based upon the results achieved.	

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F 584	Continued From page 3 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 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.	F 584		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).	F 604		10/20/23

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F 604	Continued From page 4 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: 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 ..."	F 604	Resident # 22 was evaluated for appropriateness of full-length bed rails on 9.13.2023 by Director of Nursing Services. The evaluation determined that 1/4 bed rails to be more appropriate. The full-length bed rails were removed on 9.13.2023 and replaced with 1/4 side rails. Physician and Resident Representative was notified on 9.13.2023 by Unit Manager Care plan was updated on 9.13.2023 by Unit Manger. Resident # 22 had no ill effect from this deficient practice. Resident assessed by Director of Nursing on 9.13.23 All Residents who use full-length bed rails	

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F 604	Continued From page 5 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 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	F 604	have the potential to be affected. A 100% audit was completed on 9.14.2023 by Unit Mangers for all Residents to determine if full-length bed rails were in use. No other residents identified with full length rails. An in-service was initiated on 9.13.2023 by Staff Development for nursing staff on ensuring that residents remain free of physical restraints related to the use of full-length bed rails. The Director of Nurses and/or Unit Manager will make rounds beginning 9.14.2023 (3) x week x 4 weeks then weekly x 2 weeks to ensure that Residents are without physical restraints related to the use full length-side rails bed rails. Any concerns will be immediately addressed. The results of the audits will be forwarded to the monthly Quality Assurance Committee by the Executive Director beginning 10.06.23 then review with November Quality Assurance Meeting. The Quality Assurance Committee will make recommendations for continuation of audits, frequency or discontinuation based upon the results achieved.	

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F 604	Continued From page 6 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. 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.	F 604		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered	F 695		10/20/23

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F 695	Continued From page 7 care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: 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, " ...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.	F 695	Resident # 3 Continuous Positive airway 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 9.13.23. Resident #15 was assessed by Director of Nursing on 9.12.23. All Residents who require respiratory services have the potential to be affected. 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 on 9.13.23 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	

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F 695	Continued From page 8 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 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)	F 695	to the monthly Quality Assurance Committee begining 10.06.23 and reviewed with Novemebr Quality Assusrance Meeting. The Quality Assurance Committee will make recommendations for continuation of audits, frequency or discontinuation based upon the results achieved.	

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F 695	Continued From page 9 #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 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.	F 695		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880		10/20/23

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F 880	Continued From page 10	F 880		

The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(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:

§483.80(a)(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;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(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

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F 880	Continued From page 11 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. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(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 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	F 880	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 was 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255116	A. BUILDING _____ B. WING _____	09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 12 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 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	F 880	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 times per 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 and reviewed in November Quality Assurance Committees. The Quality Assurance Committee will make recommendations for continuation of audits, frequency or discontinuation based upon the results achieved.	

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F 880	Continued From page 13 Interview for Mental Status (BIMS) score of 12 which indicated her cognition was moderately impaired.	F 880		