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 _____	C 09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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

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 _____	C 09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 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		

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 _____	C 09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 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

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 _____	C 09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 500	Continued From page 3	M 500		

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.

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 _____	C 09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 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	

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 _____	C 09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 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.	

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 _____	C 09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 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		

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 _____	C 09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 500	Continued From page 7	M 500		

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.

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 _____	C 09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 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		