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	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeland Nursing and Rehabilitation Center LLC	3680 Lakeland Lane Jackson, MS 39216

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 48669 Based on staff and Resident Representative (RR) interviews, record review, facility investigation, and policy review the facility failed to ensure nursing staff treated residents with respect and dignity during procedures and medication administration for two (2) of eight (8) residents sampled. Residents #5 and Resident #6. Findings Include: Record review of the facility's policy titled, Resident [NAME] of Rights, reviewed/revised on 1/23, revealed, Each resident has a right to a dignified existence . and communication with and access to persons and services inside and outside the facility in a manner and in an environment that promotes maintenance or enhancement of (his or her) quality of life .10. Reside and receive services in the facility with reasonable accommodation or resident needs and preferences . Resident #5 During an interview with Resident #5 on 5/19/24 at 1:22 PM, she stated Licensed Practical Nurse (LPN) #1 was disrespectful and demanding when she entered her room to collect a urine sample. She explained that this conduct was nothing new. This nurse had frequently treated her in this manner. She stated that, despite her desire to avoid interaction with the nurse because she becomes uneasy around her, she just followed all of the instructions given to her during the process. She pointed out the facility is only now transferring her meds to another nurse, despite her repeated complaints that the current nurse is disrespectful. She added that even though another nurse administered her medications, LPN#1 still worked on her hall, which made her nervous to see her. Resident #5 shared her wishes not to see the nurse at all. Record review of a handwritten statement written by LPN #1 dated 4/24/24 revealed .Asked resident how she cleaned herself and she stated after I get through, I wipe myself .Noted with a lot of nasty toilet paper between her legs, in her vaginal area . Informed resident this is probably why you're hurting because this tissue is nasty . Record review of the police department Voluntary Statement dated 4/24/24 revealed, .She spread me wide and started wiping hard and it was hurting .I was afraid she was going to do me bodily harm. Her body language and tone of voice said so. The hold time she was digging and stretching, I was yelling Stop You're hurting me. She would not stop . (continued on next page)

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.

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Supervisor Investigation Summary Form dated 04/24/2024 at 8:45 AM, revealed facility's investigation revealed Resident #5 made an allegation of employee-to-resident abuse that occurred on 4/19/24. The facility's findings revealed that the allegations of abuse were not valid and that the resident was reassigned to another unit related to the resident not liking the Licensed Practical Nurse (LPN). In an interview with the RR on 5/20/24 at 9:48 AM, she disclosed that she had previously informed the Director of Nursing (DON) and Administrator on numerous occasions that her mother had reported LPN#1 was unkind and disrespectful to her. Nevertheless, she asserts that they would defend the nurse, suggesting that the situation is not as severe as her mother portrayed it. In the absence of any evidence, she was unable to take any action. However, in the present scenario involving the urine sample, she insisted that the nurse stop administering her mother's medications. Subsequently, they transferred her medications to another nurse. She noted that the Administrator offered her mother a relocation to a different area of the facility, but she declined. However, she believes the nurse should have relocated to a different hall. She also stated from what she gathers, her mother experiences anxiety upon encountering the nurse and tries to avoid her. During an interview with LPN #1 on 5/20/24 at 10:53 AM, she verified that she was the nurse responsible for entering Resident #5's room to collect a urine sample. She also disclosed that she typically works the night shift in the north corridor, which is where Resident #5 is located. Furthermore, she frequently picks up extra shifts in the central hall. She clarified that the medications for Resident #5 were transferred to another nurse due to her knowledge that the resident harbors animosity toward her and makes up stories about her. She also mentioned that there are other residents who lie and disapprove of her because she refuses to let them have their way. In an interview with the Unit Manager (LPN#2) for north hall on 5/21/24 at 10:13 AM, she confirmed that Resident #5 did express concerns about LPN#1 before this current complaint. However, she would have to check her notes to remember the actual concerns. On 5/21/24 at 10:25 AM, during the interview with the DON, she said there is just a personality conflict between LPN#1 and the resident because she is a by-the-book nurse. She says Resident #5 tends to want to take multiple medications at one time, and LPN #1 tells her she cannot give them all at one time. She points out that LPN #1 is very tall and has a deep voice, so her presence and tone can come across as harsh. She thinks Resident #5 is accusing the nurse of being rude because of the nurse's outward appearance, tone, and pitch. A record review of the Face Sheet of Resident #5 revealed the facility admitted the resident on 5/12/17. Her diagnoses included Urinary Tract Infection, Paranoid Schizophrenia, and Generalized Anxiety Disorder. A record review of Resident #5's annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 4/24/24 revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. Resident #6 (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/20/24 at 10:35 AM, during an interview with Resident #6, she stated she reported to the Administrator about LPN #1's rudeness a few months ago, and the nurse's behavior improved. Nevertheless, LPN#1 has recently resumed her previous behavior of being demanding and rude when administering medication or performing any medical procedures with her. The resident admits that she experiences anxiety when in the presence of LPN#1 and responds to her inquiries without hesitation, merely responding with yes or no as required. She continued by stating that she had asked the Unit Manager (LPN #2) to prevent LPN #1 from returning to her room. Still, LPN#1 continues to administer her medications. The resident asserted that she should not be required to experience feelings of anxiety or nervousness in the presence of any staff members. She stated this facility is my home and the employees should be mindful of the manner in which they interact with all the residents. On 5/20/24 at 11:05 AM, during the interview with the RR of Resident #6, she revealed that in recent visits with the resident, she was told LPN #1 had started being mean and demanding again, over the last couple of weeks or so. She indicated that she could tell the nurse makes her aunt anxious, and the facility should have fired the nurse or moved her off the hall when Resident #6 had made the first complaint regarding LPN #1, back in March. On 5/22/24 at 10:48 AM, the Administrator confirmed that she was aware Resident #6 had complained about LPN #1 and addressed the allegation immediately. She acknowledged she counseled LPN#1 but did not move Resident #6's medication to another nurse or move LPN#1 to another hall. The Administrator added that as of 5/22/24, LPN #1 was moved to another hall. A record review of the Face Sheet revealed the facility admitted Resident #6 on 1/11/24. Her diagnoses included Depression and Urinary Tract Infection. A record review of the Quarterly MDS, for Resident #6, with an ARD of 4/12/24, revealed a BIMS of 15, which indicated the resident was cognitively intact.