Printed: 07/02/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255338	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lamar Healthcare & Rehabilitation Center	6428 US Highway 11 Lumberton, MS 39455

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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, record review, and facility policy review, the facility failed to ensure appropriate pain management when nursing staff failed to assess and manage pain prior to and during wound care for Resident #4 which resulted in the resident experiencing avoidable pain during wound care and failed to administer ordered pain medication for Resident #47 for two (2) of three (3) residents reviewed for pain management.Findings include: A review of the facility's policy, Pain – Clinical Protocol, undated, revealed, Assessment and Recognition.2. The nursing staff will assess each individual for pain upon admission to the facility, at the quarterly review, whenever this is a significant change in condition, and when there is onset of new pain or worsening of existing pain.4. The nursing staff will identify any situations or interventions where an increase in the resident's pain may be anticipated; for example, wound care.Monitoring.2. The staff will evaluate and report the resident/patient's use of standing and PRN (as needed) analgesics. A. Depending on the characteristics of pain, the physician may start with PRN doses or supplement standing doses with PRN doses for breakthrough pain. Resident #4 A record review of the Order Summary Report revealed Resident #4 had a physician's order dated 12/9/25 for wound care to the left heel two times daily and an additional order dated 2/27/26 for wound care to the left heel two times daily. The record review further revealed an order dated 2/18/26 for Acetaminophen (Tylenol) 500 milligrams (mg) three times daily for pain. A record review of the electronic Medication Administration Record (eMAR) for March 2026 revealed Resident #4 was scheduled to receive Acetaminophen at 1:00 PM on 3/31/26, however, the eMAR was reviewed prior to observing wound care and Resident 4's Acetaminophen was not documented as administered at that time. On 3/31/26 at 1:45 PM, during an observation, Licensed Practical Nurse (LPN) #1 performed wound care to Resident #4's left heel. During the procedure, the resident vocalized that he was in pain, stated the treatment hurt, and began crying. The nurse continued the wound care procedure without stopping to assess pain or provide pain medication. On 3/31/26 at 2:00 PM, during an interview, LPN #1 reviewed the physician's orders and initially indicated the resident did not have pain medication ordered. Upon further review, she confirmed Resident #4 had a scheduled order for Acetaminophen at 1:00 PM and acknowledged the medication had not been administered prior to performing wound care. On 3/31/26 at 2:20 PM, during an interview, the Director of Nursing (DON) stated the expectation was (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lamar Healthcare & Rehabilitation Center	6428 US Highway 11 Lumberton, MS 39455

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 0697 Level of Harm - Actual harm Residents Affected - Few	for nursing staff to assess pain prior to wound care and administer pain medication before initiating treatment when pain was anticipated. On 4/1/26 at 4:30 PM, during an interview, the Administrator stated the expectation was for staff to follow the facility's pain management policy and ensure residents received appropriate pain control during treatments such as wound care. A record review of the admission Record revealed the facility admitted Resident #4 on 10/10/25 with diagnoses including Acute Kidney Failure. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/7/26 revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of three (3), which indicated the resident's cognition was severely impaired. Resident #47 A record review of the facility's investigation revealed Resident #47 complained of right lower extremity pain on 10/20/25 and was sent to the hospital on [DATE] and returned on 10/21/25 with a diagnosis of Deep Vein Thrombosis (DVT). The record review revealed the resident continued to complain of right leg and hip pain and a mobile X-ray obtained on 10/21/25 revealed an acute nondisplaced subcapital femoral neck fracture. A record review of the Progress Notes revealed on 10/20/25 at 4:37 PM, a Certified Nurse Aide (CNA) reported Resident #47 was experiencing pain throughout the shift when being changed. The nurse documented the resident yelled out and would not move his leg and the physician was notified and an X-ray was ordered. The progress note did not address how the resident's pain was managed. A progress note dated 10/20/25 at 8:15 PM revealed the resident continued to complain of pain with movement of the right leg and was sent to the emergency department. There was no documentation pain medication was administered. A progress note dated 10/21/25 at 11:48 PM revealed the resident continued to complain of pain to the right leg and hip and did not address how his pain was managed. A record review of the Order Summary Report revealed Resident #47 had a physician's order with a start date of 10/3/24 for Acetaminophen (Tylenol) 325 milligrams (mg) to be given every eight (8) hours as needed for pain. A record review of the Medication Administration Record (MAR) for October 2025 revealed Resident #47 was assessed for pain each shift and was documented as having a pain level of 0 on 10/20/25 and did not receive any documented pain medication, including Acetaminophen, during the month. On 4/1/26 at 10:03 AM, during an observation and interview, Resident #47 was observed lying in bed and was unable to answer questions. On 4/2/26 at 10:28 AM, during an interview, Licensed Practical Nurse (LPN) #5 confirmed she worked on 10/20/25 when Resident #47 complained of right leg pain. She stated she notified the physician and received an order for an X-ray. She reported she thought she had administered Tylenol but was unable to recall and confirmed there was no documentation to support that pain medication was administered. On 4/2/26 at 11:19 AM, during an interview, the Director of Nursing (DON) confirmed the resident (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lamar Healthcare & Rehabilitation Center	6428 US Highway 11 Lumberton, MS 39455

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 0697 Level of Harm - Actual harm Residents Affected - Few	complained of pain and there was no documentation that pain medication was administered despite an order being in place. She stated she expected nursing staff to provide pain relief when residents complained of pain. On 4/2/26 at 1:23 PM, during an interview, the Administrator stated it was the expectation that nursing staff provide pain relief to residents when they complained of pain. A record review of the admission Record revealed the facility admitted Resident #47 on 4/2/19 with diagnoses including Dementia. A record review of the Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/30/26 revealed Resident #47 had a Brief Interview for Mental Status (BIMS) score of four (4), which indicated the resident's cognition was severely impaired.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lamar Healthcare & Rehabilitation Center	6428 US Highway 11 Lumberton, MS 39455

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on interview and record review, and facility policy review, the facility failed to ensure Registered Nurse (RN) staffing was adequate to meet the needs of residents and failed to designate a licensed nurse to serve as the designated charge nurse for each tour of duty for one (1) of four (4) days of survey. Findings include:A review of the facility's policy, Staffing, Sufficient and Competent Nursing, revised August 2022 revealed, .Our facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment.Policy Interpretation and Implementation Sufficient Staff.2. A licensed nurse is designated as a charge nurse on each shift.b. A charge nurse is a licensed nurse with designated responsibilities that may include staff supervision, emergency coordination, provider or physician support and direct resident care.A record review of the Facility Assessment revealed, Staffing Hours per Resident Day data for October 1 through December 31, 2025, revealed Registered Nurse (RN) hours were reported as 0.173 hours per resident per day, which equals ten (10) minutes of RN time per resident per day. The report documented an average resident census of 88.6 residents, which equals 15.3 RN hours per day based on the facility's reported staffing levels.A record review of the facility's daily assignments revealed that on 3/30/26, there was no designated Charge Nurse or RN Supervisor for the 6PM or 6AM shift.On 3/31/26 at 3:43 PM, during an interview with the Director of Nursing (DON), she reported the facility did not have sufficient RN staffing to complete weekly wound assessments for residents with pressure ulcers. The facility relies on the outpatient wound clinic to complete these assessments. She explained there was no weekly wound documentation that include measurements or assessments describing wound characteristics available for residents with wounds. On 4/1/26 at 2:35 PM, during an interview, the DON explained she also served in the capacity of the Infection Preventionist and was responsible for staffing, scheduling, and daily facility operations. She reported she had not had time to complete infection surveillance, track infections, or conduct infection control rounds for several months because she was working the medication cart or functioning as the nursing supervisor.On 4/1/26 at 3:00 PM, during an interview, the Administrator stated that the DON had sufficient time to complete infection prevention duties in addition to her other responsibilities.On 04/02/2026 at 7:45 AM, during an interview with the DON, she confirmed there was no designated charge nurse indicated on the daily assignment sheets because it was known by the staff that the Licensed Practical Nurse (LPN) or cart nurse for the hall was in charge. The DON confirmed there was no charge nurse with specific duties including staff supervision, emergency coordinator, physician liaison and direct resident care. The DON said she was unaware she was unable to function in the role of Nursing Supervisor due to the facility's census. The DON stated that the facility has posted job openings and has tried to hire RNs. On 04/02/2026 at 1:17 PM, during an interview with the Administrator, she stated that the benefit to having a licensed nurse designated as the charge nurse is to cut down on confusion and to allow the staff to know who is in charge. She stated she did not know that due to the facility census being over 60 residents, that the DON could not function in the capacity of the charge nurse or RN Supervisor. The Administrator reported that the facility has placed job listings to recruit RNs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lamar Healthcare & Rehabilitation Center	6428 US Highway 11 Lumberton, MS 39455

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on record review, facility policy review and staff interview, the facility failed to ensure the Director of Nursing (DON) did not function in the capacity of the charge nurse when the facility had more than 60 residents for four (4) of (15) days reviewed for staffing. (3/16/26, 3/17/26, 3/26/26, and 3/30/26).Findings Include:A review of the facility's policy, Staffing, Sufficient and Competent Nursing, Revision Date August 2022 revealed, Sufficient Staff.2 .c. The director of nursing services (DNS) may serve as the charge nurse only when the average daily occupancy of the facility is 60 or fewer.A record review of the facility's daily assignment document revealed the DON was listed as the RN (Registered Nurse) Supervisor on 3/16/26 and the census was listed as 88. On 3/17/26, the DON was listed as the RN Supervisor and the census was 90, on 3/26/26 the DON was listed as the RN Supervisor and the census was 94, and on 3/30/26 the DON was listed as the RN Supervisor and the census was 93. On 04/02/2026 at 7:45 AM, in an interview with the DON, she stated that she was unaware she was unable to function in that role due to facility census. The DON stated that the facility has posted job openings and has tried to hire RNs. On 04/02/2026 at 1:17 PM, in an interview with the Administrator, she stated she did not know that due to the facility census being over 60 residents, that the DON could not function in the capacity of the charge nurse or RN Supervisor. The Administrator reported that the facility has placed job listings to recruit RNs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2026
NAME OF PROVIDER OR SUPPLIER Lamar Healthcare & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6428 US Highway 11 Lumberton, MS 39455	

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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observation, interview, record review, and facility policy review, the facility failed to provide residents with alternate food options of similar nutritive value for one (1) of (19) sampled residents with the potential to affect all 89 residents in the facility. Residents #12Findings included:A review of the facility's policy Alternate Foods for Food Preferences with reviewed date of 12/23 revealed . Alternate foods and beverages are offered to residents who refuse offered off regular menu and is, served to meet individual . preferences, or requests. Procedure: . 4. The nursing assistant, on observing that a resident is refusing food, offers the always available alternate food to the resident.A record review of the facility's Always Available Menu revealed Grilled cheese, hamburger, chicken tenders, soup/salad (and/or) half of a sandwich, pimento cheese sandwich, peanut butter and jelly sandwich, and deli sandwich.A record review of the facility's menu, Fall/Winter 2025/2026 Week 1 Alternates and Modified Items revealed there were menu alternatives for each meal and each day of the week. The alternative menu included full meal options that included items such as sliced turkey, steak fingers, smoked sausage, but did not include the items listed on the Always Available Menu. The alternative menu was signed by the Registered Dietician (RD). Resident #12On 03/30/2026 at 11:55 AM, during an observation and interview, Resident #12 was eating the lunch meal which consisted of coleslaw, pulled pork, and baked beans. He reported that he doesn't always like what is served.On 03/31/2026 at 10:54 AM, during an interview, Certified Nurse Assistant (CNA) #4 stated that Resident #12 eats well depending on the menu. She reported that on the previous evening, the resident did not like the chicken alfredo served for dinner. CNA #4 explained the facility does not offer alternate meals, but that residents can get an item from the Always Available menu.A record review of Resident #12 admission Record revealed the facility admitted the resident on 7/22/24 with diagnoses including Unspecified Dementia.A record review of Resident #12's Order Summary Report revealed he had a physician's order, dated 7/22/24 for a regular diet, regular texture, and regular/thin consistency. A record review of Resident #12's Quarterly Minimum Data (MDS) with an Assessment Reference Date (ARD) of 1/30/26 revealed he had a Brief Interview for Mental Status (BIMS) Summary Score of 07, which indicated his cognition was severely impaired. On 04/01/2026 at 2:00 PM, during an observation, signage was posted outside of the main dining room that included the menu for breakfast, lunch, and dinner, but there was no alternative menu listed for lunch or dinner. On 04/01/2026 at 3:30 PM, during an interview, Dietary Manager #1 stated the facility does not offer alternative meals for lunch or dinner, because the facility has an Always Available menu in place. The Dietary Manager confirmed the always-available options included items such as soup, sandwiches, grilled cheese, burgers, salads, and chicken tenders.On 04/02/2026 at 10:01 AM, during a phone interview, the facility's RD stated she was not aware that alternative meals were not being prepared and offered per the alternate menu that she signs and approves for the facility. She reported that she knew the facility provided additional items to the residents from the Always Available menu but she was unaware that the facility had replaced the alternate menu she approves with the Always Available menu. She confirmed that selecting items from the Always Available menu alone may not provide equivalent nutritional value, as meals are required to include meat, starch, and vegetables to meet nutritional standards.On 04/02/2026 at 2:23 PM, during an interview with the Administrator, she reported that currently the facility did not prepare meals using both the regular menu and the alternate menu. She expected staff to honor residents' choices and offer other meal items from the Always Available menu when residents do not eat the meal provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2026
NAME OF PROVIDER OR SUPPLIER: Lamar Healthcare & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 6428 US Highway 11, Lumberton, MS 39455	

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 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on record review, staff interview, and facility policy review, the facility failed to develop and maintain a comprehensive facility assessment to determine the appropriate number of qualified staff needed to meet residents' needs, including sufficient licensed nursing staff coverage, affecting (89) of (89) residents in the facility. Findings include:A review of the facility's policy, Facility Assessment, revised June 2024, revealed, .Facility Assessment.4. The facility assessment is used to inform staffing decisions. a. The assessment is used to ensure there is enough staff with appropriate competencies and skill sets to meet the needs of the residents identified through the review of resident assessments and plans of care.b. The facility is used to develop and maintain a direct-care staff recruitment and retention plan.A record review of the Facility Assessment revealed Staffing Hours per Resident Day data for October 1 through December 31, 2025, documented Registered Nurse (RN) hours as 0.173 hours per resident per day, which equals ten (10) minutes of RN time per resident per day. The document further revealed an average resident census of 88.6 residents, which equals 15.3 RN hours per day based on the facility's reported staffing levels. The facility assessment did not include a breakdown of the number and type of direct care staff needed by shift did not include documentation of how resident acuity and care needs were used to determine staffing levels and did not include a documented recruitment and retention plan or a contingency plan to ensure licensed nurse coverage.On 4/2/26 at 1:17 PM, during an interview with the Administrator, she reported the facility considers census, staffing hours, and resident needs when compiling the facility assessment. She confirmed the facility assessment does not document specific staffing needs by shift and there was no documented recruitment or retention plan within the facility assessment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lamar Healthcare & Rehabilitation Center	6428 US Highway 11 Lumberton, MS 39455

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on staff interview, record review, and facility policy review, the facility failed to establish and maintain an effective infection prevention and control program when the designated Infection Preventionist, who was the Director of Nursing (DON), did not have sufficient time to perform infection prevention and control duties, resulting in a failure to conduct infection surveillance, track and trend infections, and perform infection control rounds for three (3) of five (5) months reviewed, which had the potential to affect all (89) residents in the facility. Findings include:A review of the facility's policy, Surveillance for Infections, revised July 2016, revealed, .Policy Interpretation and Implementation.1. The purpose of the surveillance of infections is to identify both individual cases and trends of epidemiological significant organism and Healthcare-Associated Infections, to guide appropriate interventions, and to prevent future infections.8. The Charge Nurse will notify the Attending Physician and the Infection Preventionist of suspected infections. a. The Infection Preventionist and the Attending Physician will determine if laboratory tests are indicated.b. The Infection Preventionist will determine if the infection is reportable.9. If transmission-based precautions or other preventative measures are implemented to slow or stop the spread of infection, the Infection Preventionist will collect date to help determine the effectiveness of such measures.A review of the facility's policy, Compliance Rounds, revised January 2012, revealed, .The Infection Preventionists shall conduct unannounced periodic infection control rounds. Policy Interpretation and Implementation.2. Infection control compliance rounds should be conducted at least quarterly or at a frequency determined by the IC (Infection Control) Committee or Quality Assurance and Assessment Committee.3. The ?Monitoring Compliance with Infection Control Checklist' should be completed during each periodic compliance round.A review of the facility's infection control records revealed there were no infection surveillance logs available to review that documented infection tracking or trending. There were also no infection control meeting minutes to review that documented infection control meetings were conducted for oversight.On 4/1/26 at 2:35 PM, during an interview, the Director of Nursing (DON) explained she also served as the Infection Preventionist and was responsible for staffing, scheduling, and daily facility operations. She reported she had not had time to complete infection surveillance, track infections, or conduct infection control rounds for several months because she was working the medication cart or functioning as the nursing supervisor.On 4/1/26 at 3:00 PM, during an interview, the Administrator explained she believed the DON had sufficient time to complete infection prevention duties in addition to her other responsibilities.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2026
NAME OF PROVIDER OR SUPPLIER: Lamar Healthcare & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 6428 US Highway 11 Lumberton, MS 39455	

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on observation, interview, and record review, the facility failed to ensure the resident's right to have verbalized grievances addressed and resolved for one (1) of (19) sampled residents. Resident #25.Findings include:On 3/31/26 at 12:25 PM, during an observation and interview with the resident's Resident Representative (RR), she stated she was concerned regarding Resident #25's toenails. The RR removed the resident's socks, and her toenails were thick and had a yellow discoloration to both feet. The RR stated that she had been voicing her concerns for over a year to the facility staff, including Certified Nurse Aide (CNA) #1, that the resident needed to have a podiatry appointment, but nothing had been set up. On 4/1/26 at 2:14 PM, during an interview with Licensed Practical Nurse (LPN) #2, she reported she was aware that Resident #25's family requested for her to go to a podiatry appointment. She explained Resident #25's nails were thick and fungal in nature. On 4/1/26 at 2:22 PM, during an interview with CNA #1, she reported concerns regarding the resident's toenails were brought to her in late February 2026 by the RR and she was aware that the resident had thick, yellow toenails.On 4/2/26 at 9:26 AM, during an interview with CNA #3/Transportation staff, she reported she is responsible for making appointments for residents. She stated she was aware that the RR had requested for Resident #25 to receive podiatry services but confirmed that no appointment had been scheduled.On 4/2/26 at 1:42 PM, during an interview with the Director of Nursing (DON), she reported that when staff became aware of the RR's request, the nursing staff should have obtained a physician's order and scheduled a podiatry visit for Resident #25. A record review of the admission Record revealed the facility admitted Resident #25 on 5/24/24 with diagnoses including Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side.A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/5/26 revealed Resident #25 had a Brief Interview for Mental Status (BIMS) score of twelve (12), which indicated the resident's cognition was moderately impaired.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2026
NAME OF PROVIDER OR SUPPLIER Lamar Healthcare & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6428 US Highway 11 Lumberton, MS 39455	

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and facility policy review, the facility failed to notify the resident representative of the resident's transfer and failed to provide information regarding the bed-hold policy for two (2) of four (4) residents sampled for hospitalizations and closed record review. Residents #7 and #93. Findings include:A review of the facility's policy, Transfer or Discharge, Facility-Initiated, Revision Date October 2022, revealed, .Notice of Transfer or Discharge.4. Notice of Transfer is provided to the resident and representative as soon as practicable before the transfer.5. Notice of Facility Bed-Hold.policies provided to the resident and representative within 24 hours of emergency transfer.6. Notices are provided in a form and manner that the resident can understand. Resident #7 A record review of the admission Record revealed the Resident #7 was initially admitted by the facility on 10/3/2025 and she was readmitted on [DATE] and she had current diagnoses including Chronic Diastolic Heart Failure. A record review of the Discharge Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/16/26 revealed Resident #7 was discharged to an acute hospital and her return was anticipated. A record review of the facility's Order Summary Report revealed Resident #7 had a physician's order, dated 03/17/2026, to send the resident to a local hospital related to elevated BNP (brain natriuretic peptide) and tachycardia (increased heart rate). Review of the medical record showed no evidence the RR was notified of the transfer and no documentation that the bed-hold policy was provided at the time of transfer or within the required timeframe. Resident #93A record review of the admission Record revealed the facility admitted Resident #93 on 11/20/25 with diagnoses including Encounter for Surgical Aftercare following surgery on the Digestive System. A record review of the Discharge MDS with an ARD of 1/17/2026 revealed Resident #93 was discharged from the facility with return anticipated to a short-term general hospital. A record review of the Order Summary Report revealed Resident #93 had a physician's order, dated 01/17/2026, to send to the resident to a local hospital emergency room (ER) for evaluation. A record review of the facility's document Private Pay Bed-Holding Agreement, dated 01/23/2026, revealed the notice was completed six (6) days after the resident's transfer/discharge from the facility on 01/17/2026.On 04/02/2026 at 10:35 AM, during an interview, the Accounts Receivable Clerk (AR) confirmed she did not send a bed-hold notice or notice of transfer to Resident #7's Resident Representative (RR) following the resident's transfer to the hospital. The AR stated this occurred because the resident had been discharged from Part A coverage and she had been trained to handle Part A discharges in this manner. The AR also confirmed that for Resident #93, the bed-hold policy was not sent to the RR until six (6) days after the resident's transfer to the hospital. The AR stated she believed she was out of the facility during that time. She stated that when she is not present in the facility, there are no designated staff assigned to process or send bed-hold notifications, resulting in the letters remaining on her desk until her return. The AR acknowledged that it is her responsibility to ensure the required forms, including notification of transfer and bed-hold policy, are provided to the resident or RR at the time of transfer or within 24 hours in the case of an emergency transfer. The AR also stated that RR needs this information to be informed about the resident's status and bed-hold policy.On 04/02/2026 at 11:06 AM, during an interview, the Administrator stated that all hospital transfer notifications are to be sent to the RR regardless of payer source. She stated her expectation is for all residents and/or their RRs are to be notified of a hospital transfer and provided the bed-hold policy at the time of transfer or within 24 hours in the case of an emergency transfer. The Administrator stated that it is the responsibility of AR to communicate with families by preparing and sending all hospital transfer notifications and bed-hold policy letters. The Administrator reported that in the absence of the AR, the Accounts Payable Clerk is expected to assume these responsibilities to ensure timely notification.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2026
NAME OF PROVIDER OR SUPPLIER Lamar Healthcare & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6428 US Highway 11 Lumberton, MS 39455	

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interviews, record review and facility policy review, the facility failed to implement comprehensive care plan interventions for three (3) of (19) sampled residents. (Resident #3, Resident #6, and Resident #25)Findings include:Review of the facility policy titled, Care Plans, Comprehensive Person-Centered with no date, revealed, Policy Statement. a comprehensive person- centered care plan that includes measurable objectives and timetables.developed and implemented for each resident.Policy interpretation and Implementation.7. The comprehensive, person-centered care plan.a. includes measurable objectives and timeframes.e. reflects currently recognized standards of practice for problem areas and conditions.Resident #3A record review of Resident #3's Care Plan Report revealed interventions for Seroquel, observe for s/s (signs and symptoms) of SE (side effects) of med (medication): dizziness, drowsiness, changes in cognition, and Remeron, observe for s/s of SE of med: dizziness, drowsiness, increased confusion. Both interventions had an initiation date of 5/22/25.During an interview on 03/31/2026 at 12:05 PM, with Licensed Practical Nurse (LPN) #1, she reported that Resident #3 has had no known side effects from taking antipsychotic and antidepressant medications. LPN #1 confirmed there was no documented evidence of monitoring for the medications side effects.A record review of Resident #3's admission Record revealed the facility admitted him on 05/09/2025 with diagnoses including Alzheimer's Disease. A record review of Resident #3's Order Summary Report with active orders as of 04/02/2026 revealed physician orders for Quetiapine Fumarate (Seroquel) Oral Tablet 25 mg to give 12.5 mg by mouth at bedtime related to Alzheimer's Disease, Unspecified (dated 2/10/26) and Remeron (Mirtazepine) Oral Tablet 15 mg Give 7.5 mg by mouth at bedtime (dated 2/10/26). No orders for monitoring the side effects of the medications were identified.A record review of Resident #3's medical records, including the Medication Administration Record (MAR), revealed there was no documentation that the resident was monitored for the side effects of antipsychotic and antidepressant medications. A record review of Resident #3's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/13/2026 revealed he had a Brief Interview for Mental Status (BIMS) score of six (6), which indicated his cognition was severely impaired. A review of Section N revealed he was administered antipsychotic and antidepressant medications. Resident #6A record review of Resident #6's Care Plan Report revealed a care plan focus for Takes psychotropics meds with interventions for Celexa ,observe for s/s of SE (side effects) of med: increased confusion, drowsiness, weakness, dizziness, tremors and Xanax, observe for s/s of SE of med: Dizziness, drowsiness, lethargy, increased confusion, blurred vision.During an interview on 03/31/2025 at 11:40 AM, with LPN #1, she reported that to her knowledge the resident has not had any adverse side effects of her prescribed psychotropic medications. She confirmed there was no place in the medical record for nurses to document that monitoring for side effects occurred. A record review of Resident #6's admission Record revealed the facility admitted the resident on 10/10/25 with diagnoses including Bipolar Disorder, Depression, Unspecified, Anxiety Disorder, Unspecified, Other Psychoactive Substance Use, Unspecified with Psychoactive Substance-Induced Mood Disorder.A record review of Resident #6's Order Summary Report with active orders as 4/2/26, revealed physician orders for Abilify (Aripiprazole) Oral Tablet 5 (five) mg (milligram) Give 5 mg by mouth at bedtime relate to Bipolar Disorder Current Episode Manic Without Psychotic Features, Unspecified (dated 11/21/25) Alprazolam (Xanax) Tablet 0.25 mg Give 1(one) tablet by mouth three times a day for anxiety (dated 2/2/26) , Citalopram Hydrobromide (Celexa) Oral Tablet 10 mg Give 1 (one) tablet by mouth one a day related to Anxiety Disorder (dated 10/10/25), and Xanax Oral Tablet 0.25 MG Give 1 (one) tablet by mouth one time a day for anxiety related to Anxiety Disorder, Unspecified (dated 1/31/26). There were no orders identified for monitoring the side effects of the medications.A record review of Resident # 6's medical records, including the MAR, revealed there was no documentation for (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lamar Healthcare & Rehabilitation Center	6428 US Highway 11 Lumberton, MS 39455

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	monitoring side effects of Antipsychotic, Antianxiety, and Antidepressant medications.A record review of Resident #6's Significant Change MDS with an ARD of 1/2/26 revealed she had a BIMS summary score of 15, which indicated her cognition was intact. A review of Section N revealed she received Antipsychotic, Antianxiety, and Antidepressant medications. Resident #25A record review of Resident #25's Care Plan Report revealed a care plan focus for High Risk for bruising/bleeding r/t (related to) Anticoagulant with intervention to observe for signs and symptoms of bleeding: unexplained bruising/spreading of an established bruise, frank bleeding, blood in urine/stool (tarry colored stool).During an observation and interview on 03/31/2026 at 10:55 AM, with Resident #25, she stated that she bruises easily and pointed to the top of her right hand, reporting that the discoloration was from a blood draw. During an interview on 03/31/2026 at 11:35 AM, with LPN #4, she stated that Resident #25 was prescribed Eliquis as an anticoagulant medication. She reported the resident was monitored for medication side effects; however, she was not aware of any documentation reflecting the monitoring. LPN #4 further stated that CNAs report any skin changes and that nurses complete weekly body audits for the residents.A record review of Resident #25's admission Record revealed the facility admitted her on 05/24/2024 with diagnoses including Chronic Atrial Fibrillation, Unspecified.A record review of Resident #25's Order Summary Report with active orders as of 04/02/2026 revealed a physician's order for Eliquis Oral Tablet 2.5 mg (Apixaban), dated 1/31/25, to give 1 (one) tablet by mouth every morning and at bedtime related to Chronic Atrial Fibrillation, Unspecified. There were no orders for monitoring for side effects of medications.A record review of Resident #25's medical records, including the MAR, revealed there was no documentation to monitor for bleeding or side effects of anticoagulant medication.A record review of Resident #25's Quarterly MDS with an ARD of 02/05/2026 revealed she had a BIMS Summary Score of 12, which indicated her cognition was moderately impaired. A review of Section N revealed she was administered anticoagulant medication. During an interview on 04/01/2026 at 4:04 PM, with the Director of Nursing (DON), she stated that the nurses are responsible for entering physician orders, including required parameters for monitoring medications. The DON confirmed that orders for medications, including anticoagulants and antipsychotics, should include monitoring for side effects and be reflected on the MAR for ongoing nurse oversight. The DON acknowledged that the care plan interventions for monitoring medication side effects were not implemented.During an interview on 04/02/2026 at 2:15 PM, with Registered Nurse (RN) #1, she reported that she expects all staff to follow the resident care plans. She acknowledged that the care plans include an intervention to observe; however, she confirmed there is no documentation to support that this intervention is being carried out.During an interview on 04/02/2026 at 2:23 PM, with the Administrator, she stated her expectation is for all staff to document care and duties required for their shift.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2026
NAME OF PROVIDER OR SUPPLIER Lamar Healthcare & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6428 US Highway 11 Lumberton, MS 39455	

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, record review, and facility policy review, the facility failed to provide assistance with activities of daily living (ADLs) related to toenail care for one (1) of three (3) residents reviewed for ADL/Nail Care. Resident #76.Findings include:A review of the facility's policy, Fingernails/Toenails, Care of, dated 02/2018, revealed, .The purpose of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infection.General Guidelines.6. Stop and report to the nurse supervisor if there is evidence of ingrown nails, infections, pain, or if nails are too hard or too thick to cut with ease.Documentation.6. If the resident refused the treatment, the reason(s) why and the intervention taken.On 3/30/26 at 2:39 PM, during an observation and interview, Resident #76's toenails were observed to be thick, long, curved, and excessive in length. The resident reported his toenails needed to be cut and stated he was unsure how long they had been in that condition.On 3/31/26 at 10:34 AM, during an interview with Certified Nurse Aide (CNA) #2, she reported Resident #76 required extensive assistance with Activities of Daily Living (ADLs) except feeding and that staff assisted with bed baths. She reported that CNAs are expected to notify nursing staff if nail care is needed and stated she had not noticed any concerns with the resident's toenails.On 3/31/26 at 11:10 AM, during an interview with Licensed Practical Nurse (LPN) #1, she reported the facility does not have an in-house podiatrist and residents must be sent out for podiatry services. She reported she had not been notified of any concerns regarding Resident #76's toenails.On 4/1/26 at 10:45 AM, during an observation and interview with LPN #5, Resident #76's toenails were observed to be long and thick. LPN #5 confirmed the toenails were abnormal and stated the condition should have been reported and followed through by nursing staff. Resident #76 stated that something needed to be done and stated willingness to see a podiatrist.On 4/1/26 at 11:05 AM, during an interview with the Director of Nursing (DON), she reported staff are expected to report changes in condition, including nail care, and ensure follow-up. She stated she had attempted to file the resident's toenails months prior, but the resident refused, and confirmed no follow-up was completed. She reported she was unsure whether a podiatry appointment had ever been scheduled.On 4/1/26 at 11:36 AM, during an interview with CNA #3/Transportation Aide, she reported she had recently been notified the resident needed a podiatry appointment; however, no appointment had been scheduled.On 4/2/26 at 2:50 PM, during an interview with the Administrator, she reported staff are expected to ensure residents' care needs are met.A record review of the admission Record revealed the facility admitted Resident #76 on 6/28/22 and readmitted on [DATE] with diagnoses including Encounter for Surgical Aftercare Following Surgery on the Genitourinary System.A record review of the Significant Change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/29/26 revealed Resident #76 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated he was cognitively intact. A review of Section GG revealed he required assistance with self-care, including bathing and personal hygiene.A record review of the Order Summary Report revealed Resident #76 had a physician's order, 9/8/22 for weekly head-to-toe body audits and to inform the supervisor or physician of any new skin concerns.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2026
NAME OF PROVIDER OR SUPPLIER: Lamar Healthcare & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 6428 US Highway 11 Lumberton, MS 39455	

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, record review, and facility policy review, the facility failed to ensure required cautionary signage was in place for a resident receiving oxygen therapy for one (1) of (1) resident reviewed for respiratory care. Resident #45.Findings Include:A review of the facility's policy, Oxygen Administration revised October 2010, revealed, .Equipment and Supplies.4. No smoking/oxygen in use signs.Steps in the Procedure.2. Place an oxygen in use sign on the outside of the room entrance door.3. Place an oxygen in use sign in a designated place on or over resident's bed.On 3/30/26 at 12:55 PM, during an observation, Resident #45 was in bed receiving oxygen at two (2) liters per minute via nasal cannula. No oxygen-in-use signage was observed on or near the resident's door or above the resident's bed.On 4/1/26 at 2:25 PM, an interview with Licensed Practical Nurse (LPN) #2 revealed the resident was placed on oxygen in January 2026 due to flu and pneumonia and stated that she received oxygen therapy continuously. LPN #2 confirmed that oxygen-in-use signage is required to be posted on the doors of residents receiving oxygen.On 4/2/26 at 1:42 PM, in an interview with the Director of Nursing (DON), she stated that it was her expectation that oxygen signage be posted on the doors for residents receiving oxygen therapy. She confirmed that nursing staff are responsible for ensuring the cautionary signage is present.A record review of the admission Record revealed the facility admitted Resident #45 on 10/15/18, with diagnoses including Alzheimer's Disease.A record review of the Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/7/26, revealed Resident #45 had a Brief Interview for Mental Status (BIMS) score of 03, which indicated her cognition was severely impaired. A review of Section O indicated Resident #45 received oxygen therapy.A record review of the Order Recap Report revealed Resident #45 had a physician's order, dated 1/7/26, for oxygen at (2) liters via nasal cannula every shift for shortness of breath.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2026
NAME OF PROVIDER OR SUPPLIER Lamar Healthcare & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6428 US Highway 11 Lumberton, MS 39455	

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, record review, and facility policy review, the facility failed to ensure appropriate monitoring and documentation of potential adverse consequences for psychotropic and high-risk medications, including anticoagulants, for three (3) of five (5) residents sampled for unnecessary medications. Resident #3, Resident #6, and Resident #25.Findings include:A review of the facility's policy Adverse Consequences and Medication Errors with the revision date of February 2023 revealed . The interdisciplinary team monitors medication usage in order to prevent and detect medication-related problems such are adverse drug reactions (ADRs) and side effects. Policy Interpretation and Implementation Adverse Consequences 1. An adverse consequence: refers to an unwanted, uncomfortable or dangerous effect that a drug may have, such as a decline in mental or physical condition, or functional or psychosocial status. An adverse consequence may include: a. Adverse drug/medication reaction. b. side effect . 3. Residents receiving medication are monitored for adverse consequences . Procedures . 4. Monitor the resident for medication-related adverse consequences .Resident #3On 03/31/2026 at 11:25 AM, during an observation and interview, Resident #3 was awake and lying in bed and he stated that he is sometimes forgetful. On 03/31/2026 at 12:05 PM, during an interview, Licensed Practical Nurse (LPN) #1 stated that Resident #3 has dementia and confusion but has not exhibited any type of behaviors or agitation. She reported that he has had no known side effects from taking antipsychotic medications. LPN #1 confirmed there was no documented evidence of the monitoring for the medication side effects. She stated she was aware of the potential side effects of the medications and that staff monitored his behaviors.A record review of Resident #3's admission Record revealed the resident was admitted on [DATE] with diagnoses including Alzheimer's Disease. A record review of Resident #3's Order Summary Report with active orders as of 04/02/2026 revealed physician orders for Quetiapine Fumarate (Seroquel) Oral Tablet 25 mg (milligrams) to give 12.5 mg by mouth at bedtime related to Alzheimer's Disease, Unspecified (dated 2/10/26) and Remeron (Mirtazepine) Oral Tablet 15 mg Give 7.5 mg by mouth at bedtime (dated 2/10/26). There were no orders for monitoring the side effects of the medications.A record review of Resident #3's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/13/2026 revealed a Brief Interview for Mental Status (BIMS) score of six (6), which indicated his cognition was severely impaired. A review of Section N revealed he was administered antipsychotic and antidepressant medications. A record review of Resident #3's medical records, including the Medication Administration Record (MAR), revealed there was no documentation that the resident was monitored for the side effects of the medications. Resident #6On 03/31/2025 at 11:40 AM, during an interview with LPN #1, she reported that Resident #6 was currently out of facility with her boyfriend. LPN #1 reported that to her knowledge the resident has not had any adverse side effects of her prescribed psychotropic medications. She confirmed there was no place in the medical record for nurses to document that monitoring for side effects occurred. A record review of Resident #6's admission Record revealed the facility admitted the resident on 10/10/25 with diagnoses including Bipolar Disorder, Depression, Unspecified, Anxiety Disorder, Unspecified, Other Psychoactive Substance Use, Unspecified with Psychoactive Substance-Induced Mood Disorder.A record review of Resident #6's Order Summary Report with active orders as 4/2/26, revealed physician orders for Abilify (Aripiprazole) Oral Tablet 5 (five) mg (milligram) Give 5 mg by mouth at bedtime relate to Bipolar Disorder Current Episode Manic Without Psychotic Features, Unspecified (dated 11/21/25) Alprazolam (Xanax) Tablet 0.25 mg Give 1(one) tablet by mouth three times a day for anxiety (dated 2/2/26) , Citalopram Hydrobromide (Celexa) Oral Tablet 10 mg Give 1 (one) tablet by mouth one a day related to Anxiety Disorder (dated 10/10/25), and Xanax Oral Tablet 0.25 MG Give 1 (one) tablet by mouth one time a day for anxiety related to Anxiety Disorder, Unspecified (dated 1/31/26). There were no orders for monitoring the side effects of the medications.A record review of Resident #6's (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2026
NAME OF PROVIDER OR SUPPLIER Lamar Healthcare & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6428 US Highway 11 Lumberton, MS 39455	

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Significant Change MDS with an ARD of 1/2/26 revealed she had a BIMS summary score of 15, which indicated her cognition was intact. A review of Section N revealed she received Antipsychotic, Antianxiety, and Antidepressant medications. A record review of Resident # 6's medical records, including the MAR, revealed there was no documentation for monitoring side effects of Antipsychotic, Antianxiety, and Antidepressant medications.Resident #25On 03/31/2026 at 10:55 AM, during an interview and observation, Resident #25 was lying in bed. She stated that she bruises easily and pointed to the top of her right hand, reporting that the discoloration was from a blood draw. On 03/31/2026 at 11:35 AM, during an interview, LPN #4 stated that Resident #25 was prescribed Eliquis as an anticoagulant medication. She reported the resident was monitored for medication side effects; however, she was not aware of any documentation reflecting the monitoring. LPN #4 further stated that CNAs report any skin changes and that nurses complete weekly body audits for the residents.A record review of Resident #25's admission Record revealed the facility admitted her on 05/24/2024 with diagnoses including Chronic Atrial Fibrillation, Unspecified.A record review of Resident #25's Order Summary Report with active orders as of 04/02/2026 revealed a physician's order for Eliquis Oral Tablet 2.5 mg (Apixaban), dated 1/31/25, to give 1 (one) tablet by mouth every morning and at bedtime related to Chronic Atrial Fibrillation, Unspecified. There were no orders for monitoring for side effects of medications.A record review of Resident #25's Quarterly MDS with an ARD of 02/05/2026 revealed she had a BIMS Summary Score of 12, which indicated her cognition was moderately impaired. A review of Section N revealed she was administered anticoagulant medication. A record review of Resident #25's medical records, including the MAR, revealed there was no documentation to monitor for bleeding or side effects of anticoagulant medication.On 04/01/2026 at 4:04 PM, during an interview, the Director of Nursing (DON) stated that the nurses are responsible for entering physician orders, including required parameters for monitoring medications, and are trained to do so. The DON confirmed that orders for medications, including anticoagulants and antipsychotics, should include monitoring for side effects and be reflected on the MAR for ongoing nurse oversight. The DON acknowledged there are certain medications that require monitoring for side effects, which should be documented, with the physician notified of any adverse findings.On 04/02/2026 at 2:23 PM, during an interview, the Administrator stated her expectation is for all staff to document care and duties required for their shift.