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	255116	A. BUILDING _____ B. WING _____	C 12/05/2023

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LAKELAND NURSING AND REHABILITATION CENTER LLC	3680 LAKELAND LANE JACKSON, MS 39216

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F 000	INITIAL COMMENTS The State Agency (SA) conducted Complaint Investigation (CI), MS #23353, at the facility, from 12/04/23 through 12/05/23. CI MS #23353 was investigated for Quality of Care/Treatment related to a resident with body odor, inadequate grooming, resident left wet for extended periods, resident left soiled for extended periods, resident neglect related to Pressure Sores, resident rights, and misappropriation of resident property/clothing. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F677. Based on the facility's implementation of corrective actions completed on 11/15/23, the SA determined F761 to be Past Non-Compliance (PNC) and corrected as of 11/15/23, prior to the SA's first entrance on 12/04/23. The facility was licensed for 105 beds and had a census of 84 at the time of the survey.	F 000		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to provide Activities of Daily Living (ADL) care regarding fingernail care for residents who are dependent upon staff for two (2) of four (4) sampled residents. Resident #1 and Resident #2	F 677	1. Resident #1 and Resident #2 received nail care by Treatment Nurse. Nails were trimmed and cleaned. Director and Executive Director to monitor residents #1 and #2 for compliance of nail care. 2. All residents who receive assistance	1/18/24

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

Electronically Signed | 12/22/2023

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F 677	Continued From page 1 Findings Include: Record review of the facility's policy, "Fingernails/Toenails Care", reviewed 10/09, "POLICY:The purpose of this procedure is to clean the nail bed, to keep nails trimmed, and to prevent infections. Responsibility: Nursing Assistant or Licensed Nurse ...1. Nails can be partially cleaned during bath care ...3. Nail care includes daily cleaning and regular trimming..." Resident #1 On 12/04/23 at 4:00 PM, an observation and interview with Resident #1 revealed she had contractures of both hands, and all of her fingernails were long. There was a black substance caked under her right thumbnail. Resident #1 stated that she did not prefer to have long fingernails and wanted her fingernails trimmed. The resident said she could not recall the last time her fingernails were trimmed. On 12/05/23 at 10:30 AM, during a telephone interview with the Resident Representative (RR) for Resident #1 revealed that she did not feel that Resident #1 received adequate grooming/fingernail care. Record review of the "Face Sheet" revealed the facility admitted Resident #1 on 1/09/18 and she had diagnoses including Parkinson's disease and Dementia. Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 12/04/23 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated her cognition was	F 677	with Activities of Daily Living (ADL) care regarding fingernail care have the potential to be affected from this deficient practice. 3. An in-service was initiated on 12/15/2023 by Director of Nursing staff regarding providing residents with assistance with Activities of Daily Living (ADL) and proper nail care to residents. On 12/12/23 the Director of Nursing and facility Treatment Nurse conducted a 100% audit of all residents to identify any residents that required nail care. 4. The Director of Nursing and Treatment nurse will audit 5 residents 3 times per week for 2 weeks beginning 12/18/23. Then weekly for 3 weeks to ensure assistance with Activities of Daily Living and nail care is provided. The results of audit will be forwarded to monthly Quality Assurance Committee on 01/08/2024 and monthly for 2 months.	

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moderately impaired.

Resident #2

On 12/04/23 at 4:20 PM, an observation of Resident #2, revealed the resident had ten (10) long fingernails with a brown/black substance under all ten fingernails.

Record review of the "Face Sheet" revealed the facility admitted Resident #2 on 5/14/2014 with diagnoses that included Dementia and Polyosteoarthritis, unspecified.

Record review of the Quarterly MDS with an ARD of 9/26/23 revealed Resident #2 required a staff assessment for mental status and her cognition was severely impaired. Section GG revealed she was dependent upon staff for showering/bathing.

On 12/04/23 at 4:35 PM, an interview with Certified Nurse Aide (CNA) #1 confirmed that the facility provided in-service training to all nursing staff regarding the care of residents that required assistance with ADLs. She confirmed that fingernail care to keep fingernails clean, trimmed, and smooth was included in ADL care. CNA #1 stated that CNAs were supposed to observe residents' fingernails daily and residents were supposed to receive fingernail care to clean, trim and smooth fingernails, according to resident preference as needed based on observation. The CNA confirmed that Resident #1 and Resident #2 had long fingernails that needed to be trimmed and there was dirt under the nails.

On 12/05/23 at 1:00 PM, during an interview with the Wound Care Nurse, she revealed that resident fingernails were to be observed daily by

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F 677	Continued From page 3 nursing staff, CNAs, and nurses, and care was to be provided as needed, including cleaning, trimming, and filing. The Wound Care Nurse stated that Resident #1 had long fingernails that "need to be trimmed" and that the resident's right thumb nail "needs cleaning, it's dirty under there". The Wound Care Nurse stated that long, dirty fingernails increased the risk of infection. The Wound Care Nurse said that Resident #2 also needed fingernail care. On 12/05/23 at 3:15 PM, an interview with CNA #4 revealed that the facility policy was that CNAs were to provide residents with fingernail care as needed for cleaning and that if there were reasons the CNA could not trim the fingernails and they needed to be trimmed the CNA was to report the observation to the Wound Care Nurse or the resident's assigned nurse.	F 677		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 761		

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F 761	Continued From page 4 §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, policy review, record review, and interviews, the facility failed to ensure secure storage of medication included limited of access, for one (1) of four (4) sampled residents reviewed for pressure sores as evidenced by skin protectant ointment left unattended at resident's bedside. Resident #1. Findings Include: Record review of the facility policy titled "Medication Storage" ,reviewed 11/10 revealed "POLICY: Medication supply must be accessible only to licensed nursing personnel, or staff members lawfully authorized to administer medications. All drugs, treatments, and biologicals must be stored securely and following the manufacturer's labeled recommendations, or per facility policy..." Record review of a handwritten statement dated 11/14/23 and signed by Certified Nursing Assistant (CNA) #2 revealed that she fed some of a "white substance" she noticed next to the resident's supper tray to the resident. Record review of the Resident Incident Report dated 11/14/23 at 6:00 PM revealed that CNA #1	F 761	Past noncompliance: no plan of correction required.	

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reported that Resident #1 had ingested approximately five (5) cubic centimeters (cc) of Zinc Oxide. The report stated that Poison Control was contacted with recommendations to increase water intake. The resident was assessed by the Director of Nursing Services (DNS), including vital sign measurement and neuro assessment. Resident #1's primary physician and responsible party were notified.

Record review of a Physician's Telephone Orders for Resident #1, dated 9/19/2023, revealed " ... CLEAN EXCORIATED SKIN TO LEFT GLUTEAL FOLD ...APPLY ZINC OXIDE OINTMENT TOPICAL DAILY UNTIL HEALED."

Record review of a handwritten statement dated 11/14/23 and signed by Licensed Practical Nurse (LPN #3) stated that CNA #1 reported to her that CNA #2 had fed Resident #1 "some white cream that was not food".

On 12/04/23 at 4:00 PM, an interview with Resident #1, revealed she had no recollection of being fed zinc oxide and denied feeling nausea or abdominal pain.

On 12/05/23 at 10:30 AM, a telephone interview with the Resident Representative (RR) for Resident #1 revealed she had been concerned that a CNA had fed zinc oxide skin protectant to Resident #1. She stated that she had been notified at approximately 6:30 PM on the evening of 11/14/23 that Resident #1 had ingested zinc oxide intended for topical use on her buttocks areas, after being fed the substance by a CNA during the evening meal. Resident #1's RR stated that she had not noted any adverse reaction or change in the condition of Resident #1 since the

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11/14/23 incident.

On 12/05/23 at 11:07 AM, a telephone interview with CNA #2 revealed the CNA confirmed that there was a plastic medication cup that contained a "white cream" on the over the bed tray of Resident #1 at approximately 6:00 PM on 11/14/23 when she had gone to assist Resident #1 to eat her supper. CNA #2 stated that she fed "about a half of a teaspoon of it" to Resident #1. CNA #2 stated that CNA #1 had entered the resident's room at that time and informed her that the white substance was not food. CNA #2 said the resident's nurse was notified immediately. CNA #2 stated that she worked for a staffing agency and that 11/14/23 was the second day she had worked at the facility. She stated that following the incident she provided a written statement and left the facility and had not returned. She stated that she was not allowed to work at the facility anymore. CNA #2 stated that no one had instructed her to feed the substance to the resident.

On 12/05/23 at 1:30 PM an interview with the Director of Nursing Services (DNS) revealed that she confirmed that she had been made aware of the incident in which Resident #1 ingested zinc oxide on 11/14/23 at approximately 6:00 PM. She stated that she had immediately removed CNA #2 from all assignments, requested a written statement from CNA #2 and went to the resident's room and assessed the resident, including measurement of vital signs and neurochecks, which were all within normal limits. She stated that she contacted the Poison Control Center emergency hotline and reported the ingestion and received information to monitor the resident for nausea and increase water intake by mouth. The

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DNS stated that she notified the Emergency Department and prepared an In-Service Training for all nursing staff, which included proper storage and securement of medications. She said she also prepared a report for the Quality Assurance and Performance Improvement (QAPI) committee. She confirmed that she participated in audits of resident rooms for unsecured or unadministered medications and had observed none. The DNS reported that a QAP) Committee had met on 11/15/23 in response to the incident, during which it reviewed the policy and procedures for medication storage and administration with no changes noted. The DNS stated, "Medication should not have been left in the room, period". The DNS stated that Resident #1 had no signs or symptoms of adverse reactions following the incident.

On 12/05/23 at 1:00 PM during an interview with the Wound Care Nurse, she revealed that she did not recall leaving a medicine cup of unused zinc oxide at the bedside of Resident #1 on 11/14/23. She stated that the nurses who performed wound care and medication nurses for each unit each had a key to the treatment cart on each hall, which was where the skin protectant ointments were stored. She confirmed that she had received facility provided in-service training regarding the storage and security of medications and not leaving medications in resident rooms on 11/14/23. She confirmed that skin protectant ointments, such as zinc oxide were to be administered by a licensed nurse and any remaining ointment was to be discarded in the appropriate, secure receptacle outside the resident's room.

Record review of the "Face Sheet" revealed the

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facility admitted Resident #1 on 1/09/18 with diagnoses that included Dementia.

Record review of the Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/04/23 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated Resident #1 had moderate cognitive impairment.

Based on the facility's implementation of corrective actions on 11/15/23, the State Agency (SA) determined the deficiency to be Past Non-Compliance (PNC) and the deficiency was corrected as of 11/15/23, prior to the SA's first entrance on 12/4/23.

Validation:

On 12/04/23 through 12/05/23, the SA validated through staff interviews, record review, and facility policy review the facility began an immediate investigation when the incident occurred.

The SA validated through record review of the Resident Incident Report dated 11/14/23 that CNA #1 reported that Resident #1 had ingested approximately five (5) cubic centimeters (cc) of Zinc Oxide. The report stated that Poison Control was contacted with recommendations to increase water intake. The report documented that the resident was assessed by the DNS, including vital sign measurement and neuro assessment and that Resident #1's primary physician and responsible party were notified on 11/14/23.

The SA validated through a telephone interview with CNA #2 that the resident's nurse was notified immediately. CNA #2 stated that she worked for a

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staffing agency and that 11/14/23 was the second day she had worked at the facility and that following the incident she was removed from duty and instructed to provide a written statement and left the facility and had not returned. She stated that she was not allowed to work at the facility anymore.

The SA validated through record review of the 'Educational In-Service Record' with attached sign-in sheets dated 11/14/23 and 11/15/23 that the facility provided in-service training regarding mediations/ointments left at bedside which included "Nurses are to remove all medication cups when leaving room" and "Nursing staff must ensure no medications to include Lantiseptic, zinc oxide or other cream barriers are left in resident rooms" to all nursing staff.

The SA validated through an interview with CNA #1 that the facility provided in-service training to all nursing staff regarding medication storage, specifically nurses not leaving medications in resident rooms, and instructing CNAs to immediately notify their supervisor if they observed any medications unattended by nurses in resident rooms.

The SA validated through an interview with LPN #4 that on or around 11/14/23 she had received facility provided in-service training regarding proper storage and securement of medications and treatment ointments which included instructions that no medications or treatment ointments should be left at in any resident's room.

The SA validated through record review of the facility "QAPI Project" record dated 11/15/23 that the QAPI committee identified, "Problem

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Identified Treatment medication left in residents room Action 1. Nursing staff educated on not leaving barrier creams (Lantiseptic, Zinc Oxide) or any other medications in resident rooms 2. Resident rooms monitored three times per week for four weeks to ensure medication and barrier cream not left in rooms Assessment 1. ED (Executive Director) and DNS to conduct monitoring for compliance Conclusion Documentation of conclusion to be provided to ED weekly for one month. Findings reported to QA Committee for review."

The SA validated during an interview with the Wound Care Nurse, that she had received facility provided in-service training regarding the storage and security of medications and not leaving medications in resident rooms on 11/14/23. She confirmed that in-service instructions included that skin protectant ointments, such as zinc oxide were to be administered by a licensed nurse and any remaining ointment was to be discarded in the appropriate, secure receptacle outside the resident's room.

The SA validated through an interview with the DNS that she had been made aware of the incident in which Resident #1 ingested zinc oxide on 11/14/23 at approximately 6:00 PM. She stated that she had immediately removed CNA #2 from all assignment, requested a written statement from CNA #2 and went to the resident's room and assessed the resident, including but not limited to measurement of vital signs and neurocheck, all within normal limits. She stated that she contacted the Poison Control Center emergency hotline and reported the ingestion and received information to monitor the resident for nausea and increase water intake by mouth. The

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DNS stated that she notified the ED and prepared an In-Service Training for all nursing staff, which included proper storage and securement of medications. She said she also prepared a report for the QAPI committee. She confirmed that she participated in audits of resident rooms for unsecured or unadministered medications and had observed none. The DNS reported that the QAPI Committee had met on 11/15/23 in response to the incident, during which it reviewed the policy and procedures for medication storage and administration with no changes noted. The DNS confirmed that the staffing agency had been contacted and that a "Do Not Return" request was issued for CNA #1.

The SA validated through record review of the Medication Room Monitoring Audit Tool (Three times a week for 4 weeks)" dated 11/15/23 through 12/01/23 and signed by the ED and DNS that resident rooms were audited for medications/barrier creams left in resident rooms and that none were observed during audits.