

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25LI	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/18/2022
NAME OF PROVIDER OR SUPPLIER LAKELAND NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 a Complaint Investigation (CI), MS #18571, MS #18417, MS #18335, MS #18254 at the facility from 3/16/22 through 3/18/22. During the survey, the SA determined the facility was in compliance with the requirements for participation in the Minimum Standards for Institutions For The Aged or Infirm. The SA did not substantiate MS #18571 for pressure sores, infection control, physician orders not followed, family notification. The SA did not substantiate MS #18417 for infection control. The SA did not substantiate MS #18335 for no pressure sore preventions. The SA did not substantiate MS #18254 for no pressure sore preventions, family notification, no hydration, physician order not followed and there were no deficiencies cited.	M 000		

Mississippi State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

04/18/22