

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 03/22/2023
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 at the facility for three (3) complaints, MS #20872 for alleged neglect of a resident, not answering the facility telephone, and poor Quality of Care of Residents by staff; MS #20876 for alleged smells of feces and urine in the building, and vomit on the floor; and MS #21008 for staff refusing to assist a resident to use the restroom and she urinated on herself. During the survey, the SA determined the facility was in compliance with the Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm and cited no deficiencies.	M 000		

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

04/13/23