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	09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeland Community Care Center	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. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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	Based on record review, facility policy review and interviews, the facility failed to ensure resident discharge rights by not providing all medications, specifically as needed pain medications, for one (1) of four (4) discharged residents. Resident #1. Findings include:Record review of the facility policy Discharge Medications with the most recent history of July 2024 revealed Procedure: 1. Medications are sent with the resident on discharge based on.the physician's order.On 9/03/25 at 3:40 PM, during an interview Licensed Practical Nurse (LPN) #1 confirmed she had been working on 6/27/25 when Resident #1 discharged home with home health care. She stated she didn't recall reviewing upcoming scheduled appointments with the resident prior to discharge. She confirmed she used the Current Medications list included in the Transfer/Discharge Reported dated 6/27/25 to review medications with the resident and that the list included a current prescription for Hydrocodone-Acetaminophen Oral Tablet 5-325 MG (milligrams) one (1) tablet by mouth every 6 hours as needed for pain. LPN #1 stated she did not send the resident's Hydrocodone-Acetaminophen tablets home with her because I was told if it was a certain number. She could not explain. She stated that she recalled discussing pain medications with other nurses but had not consulted the prescribing physician or the resident's primary healthcare provider for clarification.On 9/03/25 at 4:07 PM, during an interview the Minimum Data Set (MDS) Nurse stated that she had participated in discharge planning for Resident #1. She stated that discharge planning began upon admission. She stated that Resident #1 had been her own Representative and made her own healthcare decisions. She confirmed that Resident #1 had decided to discharge a few days early and had personally made her decision known to her primary healthcare provider (PHP) in person during an in person visit to the facility. She stated she had arranged home health care for Resident #1 prior to discharge from the facility. She stated that it was not unusual for residents to be instructed to follow-up with their PHP for refills, but that current medications should be sent home with the resident unless otherwise instructed by the physician.On 9/03/25 at 4:13 PM, during an interview with the Director of Nursing (DON) revealed residents were to be discharged with all current medications unless otherwise instructed by the resident's physician. She stated that Resident #1 had undergone hip replacement surgery approximately two weeks prior to discharge from the facility and had other pain related diagnoses and that she had been admitted with. Resident #1 had physician orders for Hydrocodone-Acetaminophen Oral Tablet 5-325 MG (1) tablet by mouth every 6 hours as needed for pain. She confirmed that the order was still current at the time of the resident's discharge from the facility and the PHP had not issued any explicit instructions or orders that the medication be discontinued. She confirmed that Resident #1 had telephoned the facility the week following discharge and complained that her Hydrocodone-Acetaminophen Oral Tablet 5-325 MG had not been sent home with her.On 9/03/25 at 4:25 PM, during an interview the Administrator stated that it was the policy of the facility that unless otherwise instructed/ordered by the PHP all medications were to be discharged with the resident following discharge conference with the resident and/or their representative during which all medications were to be discussed as well as notification of scheduled appointments.Record review of the admission Record for Resident #1 revealed the facility admitted the resident on 6/13/25 with diagnoses that included Aftercare following joint replacement surgery and End stage renal disease. Record review of the 5-Day MDS with an Assessment Reference Date (ARD) 6/20/25 revealed the resident had a Brief interview for Mental Status score of 10, which indicated moderate cognitive impairment. Section J indicated Resident #1 received PRN (as needed) pain medications and frequently had pain that interfered with sleep and limited day-to-day activities and had recent surgery, hip replacement, requiring active SNF (skilled nursing facility) care. Section N of the MDS documented that the facility assessed that the resident required administration of opioid pain management. Record review of the History and Physical (H&P) dated 6/25/25 for Resident #1, signed by her primary healthcare physician, Medical Doctor (MD) #1, revealed the resident was admitted after hospitalization for right total hip arthroplasty (THA) secondary to severe osteoarthritis/avascular necrosis unresponsive to conservative treatment who complained of postoperative right hip pain. The H&P included diagnoses of right hip pain and other acute postprocedural pain and treatment plans that included continuation of current medications and monitoring for pain control. Record review of the Order Summary Report revealed an order dated 6/13/25 for Hydrocodone-Acetaminophen Oral Tablet 5-325 MG Give (1) tablet by mouth every (6) hours as needed for pain.Record review of the Physician's Telephone Orders dated 6/27/25 revealed Discharge home with home health and medications. Record review of the Discharge Summary/Instructions