STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255182	A. Building B. Wing	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeview Nursing Center	16411 Robinson Road Gulfport, MS 39503

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interviews, record review, and facility policy review, the facility failed to ensure oxygen cautionary signage was posted on a resident's door for one (1) of 20 sampled residents (Resident #59).Findings include:A review of the facility's policy, Oxygen Administration, dated 7/24/23, revealed, .Oxygen is administered to residents who need it, consistent with professional standards of practice.Policy Explanation and Compliance Guidelines.6. Oxygen warning signs must be placed on the door of the resident's room where oxygen is in use.On 9/15/25 at 12:05 PM, an observation revealed no oxygen signage was posted on the door of Resident #59, where an oxygen concentrator was noted inside the room.On 9/16/25 at 9:00 AM, during an observation and interview, Resident #59 was observed with an oxygen concentrator in his room and there was no cautionary signage on the door. The resident stated he uses the oxygen sometimes, particularly after dialysis, when he feels tired. On 9/16/25 at 1:45 PM, during an interview with Licensed Practical Nurse (LPN) #1, she stated that Resident #59 did not use his oxygen continuously, but rather as needed after dialysis if short of breath. She confirmed there was no oxygen signage posted on the resident's door.On 9/16/25 at 4:45 PM, during an interview with the Director of Nursing (DON), she confirmed oxygen signage should have been posted on Resident #59's door because of his oxygen use.A record review of the admission Record revealed the facility initially admitted Resident #59 on 6/18/23 and he has current diagnoses including chronic kidney disease.A record review of the Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/21/25 revealed Resident #59 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated he was cognitively intact.A record review of the Order Summary Report revealed Resident #59 had a physician order, dated 6/6/25, for oxygen to be administered continuously.

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

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interviews, record review, and facility policy review, the facility failed to ensure medications were stored securely and in accordance with professional standards of practice by allowing a resident to have medications stored at the bedside without an assessment for safe self-administration, for one (1) of 20 sampled residents. Resident #86Findings include:A review of the facility's policy, Resident Self-Administration of Medication, dated 8/2024, revealed, .Policy Explanation and Compliance Guidelines.7. Bedside medication storage is permitted only when it does not present a risk to confused residents.The following conditions are met for bedside storage to occur- a. The manner of storage prevents access by other residents.8. All nurses and aides are required to report to the charge nurse on duty any medication found at the bedside not authorized for bedside storage.On 9/15/25 at 2:45 PM, during an observation, Resident #86 had eye drops in the room on the overbed table in plain view.On 9/16/25 at 9:00 AM, during an observation, Resident #86 had two (2) small bottles of eye drops sitting on the overbed table in front of her. She stated she takes Timolol Maleate Ophthalmic drops at night and Systane during the day.On 9/16/25 at 3:25 PM, during an observation and interview with Licensed Practical Nurse (LPN) #2, she reviewed the resident's electronic Medication Administration Record (eMAR) and confirmed that Resident #86 had an active physician's order for Timolol Maleate eye drops, which were to be administered by staff and were stored in the medication cart. LPN #2 observed and confirmed that Resident #86 had a container of Timolol Maleate eye drops and Systane on the overbed table in front of her. LPN #2 noted the Timolol drops were dispensed from an acute care hospital pharmacy and stated the resident must have brought the drops from home or from the hospital. Resident #86 stated someone at the facility had given her the drops and she had been using them but could not recall if she self-administered or if staff administered them. Upon leaving the room, LPN #2 stated Resident #86 was confused and not capable of safely self-administering medications. She confirmed it was unsafe for medications to be left in the resident's room and that she had not noticed the drops on the overbed table earlier in the day when administering medications.On 9/16/25 at 4:45 PM, during an interview with the Director of Nursing (DON), she acknowledged the facility had not assessed Resident #86 for safe self-administration of medications. She stated it was her expectation that all medications be stored appropriately and that medications should not be left at the bedside unless specifically authorized and assessed.A record review of the admission Record revealed the facility admitted Resident #86 on 9/11/25 with diagnoses including Aftercare Following Joint Replacement Surgery.A record review of the Order Summary Report revealed Resident #86 had a Physician's Order, dated 9/11/25, for Timolol Maleate Ophthalmic Solution. A record review of the admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/18/25 revealed Resident #86 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated she was moderately cognitively impaired.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observation, interviews, and record review, the facility failed to provide residents with an alternative meal choice of equal nutritive value for one (1) of 22 sampled residents (Resident #62).Findings included:On 9/17/25 at 11:00 AM, during an observation, the posted menu consisted of barbecue chicken, baked beans, and mixed vegetables, with no alternative entree listed.On 9/17/25 at 11:30 AM, during an observation and interview with the Dietary Manager (DM), there was no alternative entree or vegetables on the steam table. The DM stated that residents were provided with a Between Meal dining sheet, which included choices of hamburger with chips, grilled cheese with chips, cream of chicken soup with crackers, chicken noodle soup with crackers, peanut butter and jelly sandwich, or deli sandwich. She further explained that salad and chicken tenders were also available but verified the facility did not prepare any readily available alternative entrees. She stated residents requested an item from the Between Meal menu, and staff submitted the request using the sheet.On 9/17/25 at 12:45 PM, during an interview with the Registered Dietitian (RD), she reported that the facility's resident council voted a few years ago to switch from an alternative entree to the current Between Meal menu system. She explained that the Between Meal dining options did not provide the same nutritive value as the main menu but did allow residents a choice.On 9/17/25 at 1:07 PM, during an observation and interview with Resident #62, he stated he grew tired of eating the same foods over and over from the Between Meal menu. He had several boxes of snacks in his room and reported he purchased those to eat when he was served food he did not like.On 9/18/25 at 11:30 AM, during an interview with the Administrator, she confirmed the facility did not provide a readily available alternative entree of equal nutritive value. Instead, residents were allowed to choose items from the Between Meal menu as an alternative food choice.A record review of the Between Meal Dining menu revealed choices included Cheeseburger and Fries, Hamburger and chips, Grilled Cheese and chips, Cream of Chicken soup and crackers, Chicken Noodle soup and crackers, Peanut Butter and Jelly sandwich, and Deli sandwich and chips.A record review of the admission Record revealed the facility admitted Resident #62 on 11/15/2019 with current diagnoses including Hemiplegia and Hemiparesis.A record review of the Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/5/25 revealed Resident #62 had a Brief Interview for Mental Status (BIMS) score of 13 which indicated his cognition was intact.