

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/10/2025
NAME OF PROVIDER OR SUPPLIER Laurelwood Community Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1036 West Drive Laurel, MS 39440	

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)
<p>F 0580</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43283</p> <p>Based on interviews, record review, and the facility policy review, the facility failed to notify the physician of a resident with no documented bowel movement for six (6) consecutive days, which resulted in the resident being hospitalized on [DATE] for evaluation that included findings consistent with fecal impaction for one (1) of 14 sampled residents. Resident #25</p> <p>Cross Reference F684, F656</p> <p>Findings include:</p> <p>A record review of the facility's policy Notification of Changes in a Resident's Conditions or Status, undated, revealed, . It is the policy of this facility to .consult with his or her physician .changes in the resident's condition and/or status .Procedure 1. Nursing services shall be responsible for notifying the resident's attending physician when .d. There is a need to alter the resident's treatment significantly .</p> <p>A record review of the statement provided via the Administrator on facility letterhead dated 4/10/25 revealed the facility did not have a policy regarding constipation or bowel movements.</p> <p>On 04/07/25 at 02:38 PM, during a phone interview with a family member, she explained Resident #25 had been hospitalized in January because she did not have a bowel movement (BM) for a week.</p> <p>On 04/08/25 at 03:20 PM, during an interview with Licensed Practical Nurse (LPN) #1, she explained the Certified Nurse Aides (CNAs) are to notify them if a resident does not have a BM for three (3) consecutive days and the electronic health record (EHR) will trigger an alert for anyone with 3 days of no BM. She reported that the facility has standing physician's orders for medications to give if needed for residents with no BM. She confirmed that the physician is not always notified of no bowel movements unless the medications are not effective.</p> <p>(continued on next page)</p>

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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<p>F 0580</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/08/25 at 04:00 PM, during an interview with the Director of Nursing (DON), she confirmed Resident#25 was hospitalized with a fecal impaction several months ago. She explained the resident had a history of diarrhea and constipation and when she experienced diarrhea, medications were administered to stop it. The CNAs are to notify the nurse if there are no BMs in 3 consecutive days and then the nurse is to give the resident medications and notify the physician if there are no changes. She confirmed she was not aware the resident was not having BMs, and explained the physician did see the resident prior to the hospital admission in January.</p> <p>On 04/09/2025 at 10:45 AM, during a follow up interview with the DON, she acknowledged there was no documentation of nursing interventions, constipation medications administered, or provider notification regarding the gaps in bowel movements prior to the hospitalization for Resident #25.</p> <p>On 04/10/25 at 12:45 PM, during a phone interview with Resident #25's Physician, he explained he is familiar with the resident and explained the resident has had irritable bowels, with alternating patterns of diarrhea and constipation. He confirmed Resident #25 was on Lomotil for diarrhea and reported he was aware the resident was admitted to the hospital several months ago for a fecal impaction. However, he was not informed that the resident had no BMs or documentation of no BM for 6 consecutive days prior to being sent to the hospital. The facility has standing orders to follow if a resident has no BM. He confirmed that if he had been notified that Resident #25 had no BMs for consecutive days, he would have implemented orders for constipation.</p> <p>A record review of Resident #25's Admission Record revealed the facility originally admitted the resident on 03/01/2022 and she had a diagnosis of Constipation. Diagnoses added with an onset date of 2/5/2025 included Hemorrhage Of Anus And Rectum and Fecal Impaction.</p> <p>A record review of Resident #25's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/03/25 revealed a Brief Interview for Mental Status (BIMS) score of 13, which indicated she was cognitively intact. Resident dependent on staff for toileting hygiene and frequently incontinent of bowel and bladder.</p> <p>A record review of the facility's Documentation Survey Report for January 2025 revealed Resident #1 experienced multiple days without a documented bowel movement. Specifically, there was no documented bowel movement on January 1, 2, 3, and 5, and again on January 14, 15, 16, 17, 18, and 19, which was six (6) consecutive days. There was also no bowel movement documented on January 23, 24, and 28.</p> <p>A record review of the medical record revealed there was no documentation of nursing interventions, assessments, or physician notification to address Resident #25's ongoing constipation or lack of consecutive days with no BM during the month of January 2025.</p> <p>A record review of an acute hospital Summary of Care Document confirmed that Resident #1 was hospitalized from 01/30/2025 through 02/04/2025 with multiple medical issues, including a diagnosed fecal impaction.</p> <p>A record review of the Resident's Medication Administration Record (MAR) for January 2025 revealed Resident #25 continued to receive Lomotil (antidiarrheal medication) three (3) times daily despite the documented days of no BM. Additionally, no medications were administered for constipation, including Miralax (type of laxative medication) that was ordered to be administered PRN (as needed).</p>		

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<p>F 0656</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43283</p> <p>Based on interviews, record review, and the facility policy review, the facility failed to implement comprehensive person-centered care plan interventions for a resident with constipation and no documented bowel movements for consecutive days, which resulted in a Resident being hospitalized on [DATE] for evaluation that included findings consistent with fecal impaction for one (1) of 14 sampled residents. Resident#25</p> <p>Cross Reference F580, F684</p> <p>Findings include:</p> <p>A review of the facility's policy Care Plans, Comprehensive Person-Centered, reviewed 10/2022 revealed, . A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation . 7. The comprehensive, person-centered care plan: . e. reflects currently recognized standards of practice for problem areas and conditions . 10. When possible, interventions address the underlying source (s) of the problem area (s), not just symptoms or triggers. 11. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change .</p> <p>A record review of the Care Plan Report revealed Resident #25 had a comprehensive care plan with a Focus of (Proper Name of Resident #25) is at risk for constipation r/t (related to) polypharmacy. The Goal that was initiated on 10/4/2023 revealed, (Proper Name of Resident) will have a normal bowel movement at least every 3 (three) days . Interventions included Follow orders for bowel management, Glycolax powder .as needed for constipation, and Observe for/document/report to MD (medical doctor) PRN (as needed) s/sx (signs and symptoms) of complications related to constipation .fecal compaction .</p> <p>A record review of Resident #25's Admission Record revealed the facility originally admitted the resident on 03/01/2022 and she had a diagnosis of Constipation. Diagnoses added with an onset date of 2/5/2025 included Hemorrhage of Anus and Rectum and Fecal Impaction.</p> <p>A record review of Resident #25's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/03/25 revealed a Brief Interview for Mental Status (BIMS) score of 13, which indicated she was cognitively intact. Further review revealed Resident #25 is dependent on staff for toileting hygiene and frequently incontinent of bowel and bladder.</p> <p>A record review of the facility's Documentation Survey Report for January 2025 revealed Resident #1 experienced multiple days without a documented bowel movement. Specifically, there was no documented bowel movement on January 1, 2, 3, and 5, and again on January 14, 15, 16, 17, 18, and 19, which was six (6) consecutive days. There was also no bowel movement documented on January 23, 24, and 28.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A record review of an acute hospital Summary of Care Document confirmed that Resident #1 was hospitalized from 01/30/2025 through 02/04/2025 with multiple medical issues, including a diagnosed fecal impaction.</p> <p>A record review of the Resident's Medication Administration Record (MAR) for January 2025 revealed Resident #25 continued to receive Lomotil three (3) times daily despite the documented days of no BM. Additionally, MiralAX (type of laxative) was ordered PRN (as needed) and was not administered.</p> <p>In a phone interview, on 04/07/25 at 02:38 PM, Resident #25's daughter explained that her mother had been hospitalized in January because she did not have a bowel movement (BM) for a week. She had to be transferred to an acute hospital in another state and was there for almost a week because her bowels were impacted.</p> <p>In an interview on 04/08/25 at 04:00 PM, the Director of Nursing (DON) confirmed Resident#25 was hospitalized with a fecal impaction several months ago. She explained the resident had a history of diarrhea and constipation and when she experienced diarrhea, medications were administered. She confirmed Resident#25 was receiving Lomotil (antidiarrheal medication) three (3) times a day prior to the hospitalization . The CNAs are to notify the nurse if a resident goes three (3) consecutive days without a BM and the nurse should give medications and notify the physician if there are no changes. She reported she was not aware Resident #25 was not having BMs, and explained the physician did see the resident prior to the hospital admission in January. She also advised the physician after she was informed by the hospital that the resident had a fecal impaction in January.</p> <p>In a follow up interview with the DON on 04/09/2025 at 10:45 AM, she acknowledged there was no documentation of nursing interventions, constipation medications administered, or provider notification regarding the gaps in bowel movements prior to the hospitalization for Resident #25.</p> <p>In a phone interview with the physician on 04/10/25 at 12:45 PM, he confirmed Resident#25 was on Lomotil for diarrhea and reported he was aware the resident was admitted to the hospital several months ago for a fecal impaction. However, he was not informed that the resident had no BMs or documentation of no BM for six (6) consecutive days prior to being sent to the hospital. He stated that the facility has standing orders to follow if a resident has no BM. He confirmed that if he had been notified that Resident #25 had no BMs for consecutive days, he would have implemented orders for constipation.</p> <p>In an interview on 04/10/25 at 1:30 PM, LPN #3/Care Plan Nurse explained the facility has working care plans and are updated daily. She described the purpose of the care plan as providing the staff with a guideline to care for each individual resident. She expects staff to follow the care plans to provide care for the residents.</p> <p>In an interview on 04/10/25 at 1:40 PM, the DON explained she expects the staff to follow care plans to provide the highest quality of care for each resident, to follow standing orders related to no bowel movements, and to notify her and the physician of any changes in any resident. She reported there was miscommunication with the staff and the physician.</p> <p>In an interview on 04/10/25 at 1:50 PM, the Administrator explained the facility wants to provide each resident care as planned and to notify the DON and the physician of any changes.</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43283</p> <p>Based on interviews, record review, and the facility policy review, the facility failed to identify or respond to a clinically relevant pattern of constipation, which resulted in a resident being hospitalized on [DATE] for evaluation that included findings consistent with fecal impaction for one (1) of 14 sampled residents. Resident #25</p> <p>Cross Reference F580, F656</p> <p>Findings include:</p> <p>A record review of the statement provided via the Administrator on facility letterhead dated 4/10/25 revealed, . (Proper Name of Facility) does not have a policy for constipation or bowel movements.</p> <p>During a phone interview, on 04/07/25 at 02:38 PM, Resident #25's daughter explained that her mother had been hospitalized in January because she did not have a bowel movement (BM) for a week. She had to be transferred to an acute hospital in another state and was there for almost a week because her bowels were impacted.</p> <p>During an interview on 04/08/25 at 03:20 PM, Licensed Practical Nurse (LPN) #1 explained that the CNAs advise if there is a problem with a resident's BMs and the nurses receive an alert on the computer if a resident goes three (3) consecutive days without a BM. She further explained that the facility has standing orders for medications to give if a resident needs it for no BM or constipation. Usually, the nurse will administer oral medications related to constipation and if there are no results, they will use a suppository and rarely use an enema. If the medications are not effective, then the physician is notified.</p> <p>During an interview on 04/08/25 at 04:00 PM, the Director of Nursing (DON) confirmed Resident #25 was hospitalized with a fecal impaction several months ago. She explained the resident had a history of diarrhea and constipation and when she experienced diarrhea, medications were administered. She confirmed Resident#25 was receiving Lomotil (antidiarrheal medication) three (3) times a day prior to the hospitalization . The CNAs are to notify the nurse if a resident goes three (3) consecutive days without a BM and the nurse should give medications and notify the physician if there are no changes. She reported she was not aware Resident #25 was not having BMs, and explained the physician did see the resident prior to the hospital admission in January. She also advised the physician after she was informed by the hospital that the resident had a fecal impaction in January.</p> <p>During a follow up interview with the DON on 04/09/2025 at 10:45 AM, she confirmed there was no documentation of nursing interventions, constipation medications administered, or provider notification regarding the gaps in bowel movements prior to the hospitalization for Resident #25.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a phone interview with the physician on 04/10/25 at 12:45 PM, he explained Resident #25 had irritable bowels, with alternating patterns of diarrhea and constipation. He confirmed Resident#25 was on Lomotil for diarrhea and reported he was aware the resident was admitted to the hospital several months ago for a fecal impaction. However, he was not informed that the resident had no BMs or documentation of no BM for six (6) consecutive days prior to being sent to the hospital. He stated that the facility has standing orders to follow if a resident has no BM. He confirmed that if he had been notified that Resident #25 had no BMs for consecutive days, he would have implemented orders for constipation.</p> <p>A record review of Resident #25's Admission Record revealed the facility originally admitted the resident on 03/01/2022 and she had a diagnosis of Constipation. Diagnoses added with an onset date of 2/5/2025 included Hemorrhage Of Anus And Rectum and Fecal Impaction.</p> <p>A record review of Resident #25's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/03/25 revealed a Brief Interview for Mental Status (BIMS) score of 13, which indicated she was cognitively intact. Section GG revealed Resident #25 was dependent on staff for toileting hygiene and Section H revealed she was frequently incontinent of bowel and bladder.</p> <p>A record review of the facility's Documentation Survey Report for January 2025 revealed Resident #1 experienced multiple days without a documented bowel movement. Specifically, there was no documented bowel movement on January 1, 2, 3, and 5, and again on January 14, 15, 16, 17, 18, and 19, which was six (6) consecutive days. There were also no bowel movement documented on January 23, 24, and 28.</p> <p>A record review of the medical record revealed there was no documentation of nursing interventions, assessments, or physician notification to address Resident #25's ongoing constipation or lack of consecutive days with no BM during the month of January 2025.</p> <p>A record review of an acute hospital Summary of Care Document confirmed that Resident #1 was hospitalized from 01/30/2025 through 02/04/2025 with multiple medical issues, including a diagnosed fecal impaction.</p> <p>A record review of the Resident's Medication Administration Record (MAR) for January 2025 revealed Resident #25 continued to receive Lomotil three (3) times daily despite the documented days of no BM. Additionally, MiralAX (type of laxative) was ordered PRN (as needed) and was not administered.</p> <p>A record review of the Resident's Physician's Progress Notes dated 01/30/25 revealed, pt (patient) with decreased LOC (Level of Consciousness), pt noncompliant with therapy, pt with no dysuria, . good BS (bowel sounds) .</p> <p>A record review of the Resident's Physician's Progress Notes dated 02/06/25 revealed, pt with GI (Gastrointestinal) bleed .</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>43283</p> <p>Based on observation, interview, record review, and facility policy review, the facility failed to ensure appropriate incontinence care was provided, as evidenced by the failure to cleanse the skin during a brief change for one (1) of two (2) residents observed for incontinence care (Resident #13).</p> <p>Findings included:</p> <p>A review of the facility's policy titled, Perineal Care, revised 8/25/2014, revealed, .Procedure .5. Clean perineal area well with soap and warm water taking care to clean from front to back using a clean washcloth or clean area of the cloth for each stroke. 6. Rinse perineal area, moving from front to back using a clean area of the washcloth or towelette or use another clean washcloth or towelette for each stroke. (Note: Not all products require rinsing. Follow product instructions). 7. Dry perineal area moving from front to back. Use a blotting motion with towel. 8. Turn resident on side. 9. Clean, rinse (as applicable) and dry buttocks and perianal area without contaminating perineal area. 10. Remove wet incontinent pad or protective linen. Change gloves and perform hand hygiene .</p> <p>On 4/8/25 at 2:20 PM, during an observation of incontinence care, and interview with Certified Nurse Aide (CNA) #1, she explained that Resident #13 was dependent on staff for activities of daily living (ADLs) and was incontinent of bowel and bladder. Resident #13 was lying in bed, and his brief was soiled with urine. Disposable wipes were noted on the bedside table. CNA #1 removed the soiled brief and applied a clean one without cleansing or rinsing the perineal area or buttocks. The CNA repositioned the resident and covered him with a blanket.</p> <p>On 4/8/25 at 2:50 PM, during a follow-up interview with CNA #1, she confirmed she changed Resident #13's soiled brief and did not provide perineal care. She stated she was nervous during the observation and forgot, but she knew the appropriate procedure. She acknowledged that failing to cleanse the resident could contribute to urinary tract infections and skin breakdown.</p> <p>On 4/9/25 at 4:00 PM, during an interview with the Director of Nursing (DON), she stated her expectation is for staff to always provide proper incontinence care to prevent infections or skin breakdown.</p> <p>A record review of the Admission Record revealed the facility admitted Resident #13 on 3/10/25 with diagnoses including Metabolic Encephalopathy.</p> <p>A record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/16/25 revealed Resident #13 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated his cognition was severely impaired. Further review revealed he was frequently incontinent of bowel and bladder and dependent on staff for toileting hygiene.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>50751</p> <p>Based on observation, interview, and policy review, the facility failed to ensure medications were secured when a wound care treatment cart was left unlocked and unattended in a hallway for one (1) of four (4) days of the survey.</p> <p>Findings included:</p> <p>A review of the facility's policy titled Medication Administration Guidelines, revised August 25, 2014, revealed, .Procedure .2. Administration .m. During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. It may be kept in the doorway of the resident's room, with open drawers facing inward and all other sides closed. No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by .</p> <p>On 4/9/25 at 2:14 PM, during an observation on the North Hall, a wound care treatment cart was unlocked. The cart was left unattended by Registered Nurse (RN) #1, who had entered a resident's room to perform wound care. RN #1 remained in the room with the door closed until 2:34 PM. When she exited the room, she confirmed the treatment cart had been left unlocked and unattended.</p> <p>On 4/9/25 at 2:38 PM, during a follow up interview with RN #1, she confirmed the cart had been left unlocked and unattended for approximately 20 minutes. She stated that the cart should have been locked to prevent resident access. RN #1 opened the cart and demonstrated the contents, which included bactericidal isopropyl alcohol-based sanitizer wipes, Santyl ointment (used for tissue removal and debridement), normal saline, betadine, and nail clippers. She explained that these items could pose risks to residents, including gastrointestinal distress or requiring emergency care, if consumed.</p> <p>On 4/10/25 at 12:10 PM, during an interview with the Director of Nursing (DON), she confirmed that it was her expectation for staff to keep carts locked and not leave them unattended. She stated the risks of leaving wound carts unsecured included possible resident poisoning from substances such as betadine or Santyl, and unauthorized access by staff without proper training, which could result in theft or misuse of supplies. She confirmed that RN #1 should have locked the cart while it was unattended per facility policy.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>50921</p> <p>Based on observation, staff interviews, record review, and facility policy review, the facility failed to maintain a sanitary and pest-free environment in the kitchen by not ensuring effective pest control measures were implemented and sustained for two (2) of three (3) kitchen observations.</p> <p>Findings included:</p> <p>A review of the facility's policy, Sanitization (undated), revealed, .The food service area shall be maintained in a clean and sanitary manner. Policy Interpretation and Implementation 1. All kitchens, kitchen areas shall be . protected from rodents, roaches, flies, and other insects.</p> <p>A review of the facility's Pest Control Policy, dated 4/10/23, revealed, .Our facility shall maintain an effective pest control program. Policy Interpretation and Implementation 1. This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents .6. Maintenance services assist, when appropriate and necessary, in providing pest control services.</p> <p>On 4/7/25 at 10:02 AM, during the initial kitchen tour with the Dietary Manager, the dry goods storage area was observed. A cardboard box containing individually packaged cereal had small, black, rice-sized objects and shredded cardboard inside. The Dietary Manager confirmed the rice-sized objects appeared to be rat droppings. A glue trap with what appeared to be peanut butter smeared on top was observed on the floor of the pantry area. The Dietary Manager stated he was unaware of when the kitchen was last treated for rodents. He reported concern that rodents may be entering through a small gap beneath the kitchen's back door, which leads directly outside.</p> <p>On 4/9/25 at 8:50 AM, during a phone interview with the Registered Dietitian (RD), she explained she performs monthly kitchen tours at the end of each month. She stated she had not observed pest or rodent activity during those walk throughs. She stated her expectations were for dietary staff to maintain an effective pest control plan and adhere to sanitation standards.</p> <p>On 4/9/25 at 10:00 AM, during an interview with the Maintenance Supervisor, he stated he was unaware of rodent activity in the kitchen but acknowledged that rodents may have entered through a gap under the back door. He explained the rear kitchen area had a two-door system-a screen door and a solid, sealed door. He reported that staff had previously left the solid door open to allow air circulation when the air conditioning system was not functioning. He stated the air system was scheduled to be repaired that day.</p> <p>On 4/9/25 at 11:04 AM, during an observation of the assembly line plating, a live roach was observed crawling across a resident's meal tray. The tray was immediately removed after confirmation by the Dietary Manager, Dietary Aide, Head Cook, and Maintenance Supervisor.</p> <p>On 4/10/25 at 9:10 AM, during observation of the low-temperature dishwasher, a live roach was observed crawling on top of the machine.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/10/2025
NAME OF PROVIDER OR SUPPLIER Laurelwood Community Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1036 West Drive Laurel, MS 39440	
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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 4/10/25 at 1:10 PM, during an interview with the Administrator, she was informed of the pest-related concerns identified during two (2) of three (3) kitchen inspections. She stated she had been unaware of pest issues in the kitchen and acknowledged that high staff turnover had affected kitchen oversight. She emphasized that her expectations were for food to be prepared safely, the kitchen to be maintained in a clean and organized condition, and for pest infestations to be minimized.</p> <p>A record review of the facility's pest control logs revealed treatments for rodents and pests had occurred since December 2024.</p> <p>A review of the facility's pest control logs revealed the pest control company were targeting mice and roaches with roaches and rodent activity noted on visits during the monthly visits for the months of January, February, and March 2025.</p>		