

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  255352	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/18/2025
NAME OF PROVIDER OR SUPPLIER  Comfort Care Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1100 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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interviews, record review, and facility policy review the facility failed to ensure that residents were treated with dignity and respect by licensed nursing staff for two (2) of four (4) residents reviewed for resident rights (Resident #66 and #93). Findings Include: A record review of facility policy titled Resident's Rights Policy revealed the resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. On 9/29/25 at 11:43 AM, Resident #66 reported that night shift Licensed Practical Nurse (LPN)#1 raised her voice during a medication pass and spoke in a demeaning and intimidating tone. The resident stated she felt as though she was talked down to like a child. She also expressed fear of retaliation and concern for other residents who might not be able to speak up. On 9/29/25 at 2:45 PM, Resident #66's roommate, confirmed that LPN#1 was loud and intimidating and said the interaction was uncalled for and rude. On 9/30/25 at 3:15 PM, Resident #66 reiterated her account, stating that the nurse argued with her at 6:00 AM about taking a newly prescribed medication, which was upsetting her stomach. When she questioned the timing and asked about speaking to the physician, she said the nurse responded in a sarcastic tone, stating, How many times do I have to educate you before you take your meds? Resident #66 again stated this experience made her feel afraid, degraded, and intimidated. On 9/30/25 at 3:30 PM, Resident #93 stated, The nurse talks to us in a rough tone of voice, throws her weight around, talks to us like we're kids, and scares us by using her authority. That's not how you talk to someone. She identified herself as a former Certified Nursing Assistant (CNA) and emphasized that the nurse's behavior was inappropriate for long-term care. On 9/30/25 at 4:05 PM, CNA #1 reported that LPN#1 had also spoken to staff in a demeaning and vulgar manner, using profanity and insults. CNA #1 said she no longer wanted to work with the nurse due to her intimidating behavior. On 10/2/25 at 12:05 PM, in an interview with the facility scheduler, she stated that CNA #1, who rarely complains, reported on Monday morning that LPN#1 had verbally abused her during Sunday's night shift, cussing her out and calling her names. The scheduler stated the facility usually handles these types of reports by separating the staff on different halls or shifts. On 10/2/25 at 12:30 PM, in an interview with both the Administrator and the DON, they stated all residents have the right to be treated with dignity and respect. A review of the admission Record for resident #66 revealed that the facility admitted Resident #66 on 12/15/23 with diagnoses which included hemiplegia and hemiparesis following cerebral infarction. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/15/25 revealed Resident #66 had a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. A review of the admission Record for Resident # 93 indicated she was admitted on [DATE] with diagnoses which included acute on chronic systolic congestive heart failure. A record review of the MDS with an ARD of 9/8/25 revealed a BIMS score of 15 which indicated Resident #93 was cognitively intact.</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 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>Based on interview, record review, and facility policy review, the facility failed to review and resolve multiple resident grievances in a timely and effective manner, resulting in ongoing unaddressed environmental concerns expressed during three (3) of 3 consecutive months of Resident Council meetings. Findings include: A review of the Grievance Policy review date 11/17/16 revealed, Purpose To ensure the resident. right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without the fear of discrimination or reprisal . Responsibilities .The facility will review grievances in a timely manner and must make prompt efforts to resolve grievances. The facility will keep the resident appropriately apprised of its progress toward resolution .A record review of the Resident Council Meeting Minutes Reports dated 7/10/25, 8/14/25, and 9/11/25, revealed concerns expressed by the residents during the council meetings for housekeeping concerns regarding floors, trash, and cleaning the rooms in general. Resident #14 During an initial interview on 9/29/25 at 11:46 AM, Resident #14 reported that the facility does not clean the floors, empty the trash, or perform general housekeeping duties on weekends. As a result, rooms are often left unclean throughout the weekend, with no trash removal and unwashed floors. She stated that this concern has been raised during resident council meetings but has not received a response. A record review of the admission Record revealed the facility admitted the Resident #14 on 10/29/24 with diagnoses including hyperlipidemia, and unspecified atrial fibrillation. A record review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/29/25 revealed a Brief Interview for Mental Status (BIMS) score of 12 which indicated moderate cognitive impairment. Resident #96 On 9/29/25 at 2:00 PM, Resident #96 shared that she frequently experiences accidents on the floor due to loose bowel. On weekends, she is left to manage the odor and appearance of these incidents until staff return on Monday, as rooms are not cleaned during that time. She reported the issue to staff but stated that the housekeeping concern remains unresolved. A record review of the admission Record revealed the facility admitted Resident # 96 on 7/22/24 with diagnoses including malignant neoplasm of colon, unspecified. A record review of the MDS with an ARD of 8/27/25 revealed a BIMS score of 15 indicating the resident was cognitively intact. On 9/30/25 at 10:00 AM, during the resident council meeting, the State Agency (SA) asked for a show of hands from residents who still had complaints about housekeeping. All residents present raised their hands unanimously. Several voiced concerns, including statements such as, They don't do a good job of cleaning the rooms, particularly on the weekends. On 9/30/25 at approximately 12:43 PM, the Housekeeping Manager explained that her staff is responsible for entering resident rooms at least twice daily, once in the morning and once in the evening, to ensure cleanliness. She stated that trash should be emptied, and floors mopped or swept during these visits. However, she acknowledged that the department is currently understaffed and does not have personnel assigned to work weekends, which contributes to the complaints. While efforts are made to assist on weekends, she confirmed there is no dedicated staff for that time. She expressed awareness of the concerns raised during resident council meetings and emphasized that she is doing her best to address them. Ultimately, she stated that without additional staff, she is unable to make further improvements. On approximately 10/1/25 at 12:11 PM, the Administrator confirmed awareness of the ongoing housekeeping complaints voiced by residents during council meetings. He stated that he has brought the issue to the attention of the Housekeeping Supervisor, who indicated she would work on a solution. He acknowledged that staffing shortages are a contributing factor and that efforts are underway to resolve them. Nonetheless, he affirmed that it is the facility's responsibility to ensure rooms are properly cleaned and that resident grievances should be addressed promptly to prevent them from becoming persistent concerns.</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>Based on interviews and record review, the facility failed to ensure residents' right to be free from verbal abuse by staff for two (2) of three (3) residents reviewed for abuse (Residents #66 and #93). Findings include: A review of facility policy Abuse Neglect and Exploitation Policy with a reviewed date of 8/26/25 revealed Purpose: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, misappropriation of resident property and exploitation. Definitions: 3. Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. During an interview on 9/29/25 at 11:43 AM, Resident #66 reported that night shift Licensed Practical Nurse (LPN)#1 raised her voice during a medication pass and spoke in a demeaning and intimidating tone. The resident stated she felt as though she was talked down to like a child. She also expressed fear of retaliation and concern for other residents who might not be able to speak up. During an interview on 9/29/25 at 2:45 PM, Resident #66's roommate, confirmed that LPN#1 was loud and intimidating and said the interaction was uncalled for and rude. On 9/30/25 at 1:28 PM, Registered Nurse (RN) #2 stated the nurse and resident had words, and confirmed the resident had reported the nurse being loud but that was just her personality. During an interview on 9/30/25 at 1:43 PM, LPN#1 admitted that Resident #66 was resistant to taking a new medication and acknowledged speaking loudly, stating, That's just how I talk, though she claimed to have lowered her voice after the resident objected. During an interview on 9/30/25 at 2:52 PM, the Director of Nursing (DON) stated that she had not been informed of the incident, but she noted the nurse had a second, unrelated complaint the same night from the CNA about verbal abuse towards herself and other staff. On 9/30/25 at 3:15 PM, Resident #66 reiterated her account, stating that the nurse argued with her at 6:00 AM about taking a newly prescribed medication, which upset her stomach and gave her gastrointestinal symptoms. When she questioned the timing and asked about speaking to the physician, she said the nurse responded in a sarcastic tone, stating, How many times do I have to educate you before you take your meds? Resident #66 again stated this experience made her feel afraid, degraded, and intimidated. During an interview on 9/30/25 at 3:30 PM, Resident #93 stated, The nurse talks to us in a rough tone of voice, throws her weight around, talks to us like we're kids, and scares us by using her authority. That's not how you talk to someone. She identified herself as a former Certified Nursing Assistant (CNA) and emphasized that the nurse's behavior was inappropriate for long-term care. During an interview on 9/30/25 at 4:05 PM, CNA #1 reported that LPN#1 was extremely negative, loud, vulgar, and insulting to staff during the same shift. She recalled the nurse saying, Y'all some sorry Mother#####s towards her and other staff and described her as intimidating to both staff and residents. During an interview on 10/2/25 at 12:05 PM, the facility scheduler, stated that CNA #1, who rarely complains, reported on Monday morning that LPN#1 had verbally abused her during Sunday's night shift, cussing her out and calling her names. The scheduler stated the facility usually handles these types of reports by separating the staff on different halls or shifts. A record review of the admission Record for Resident # 66 revealed that the facility admitted Resident #66 on 12/15/23 with diagnoses which included hemiplegia and hemiparesis following cerebral infarction. A record review of Resident #66's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/15/25 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. A record review of the September 2025 electronic Medicine Administration Record (eMAR) dated for Resident#66 revealed the medicine Resident #66 referred to was document as being given by LPN #1 at 6AM on the day the incident occurred (9/28/25). A record review of the MDS with an ARD of 9/8/25 revealed a BIMS score of 15 which indicated Resident #93 was cognitively intact.</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>(continued on next page)</p>

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interviews, record review, and facility policy review, the facility failed to protect residents from misappropriation of resident funds and failed to implement corrective action or reimburse residents after funds were reported missing, affecting five (5) of 14 residents interviewed in Resident Council (Residents #5, #8, #17, #38, and #81). Findings include: A record review of the policy, Abuse Neglect and Exploitation Policy latest review date of 8/26/25 reveals, Purpose: It is the policy of this facility to provide protection of the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, misappropriation of resident property. On 9/30/25 at 10:15 AM, during a Resident Council meeting, Resident #85 (Council President) stated to the State Agency (SA) that multiple residents had reported their money was stolen a few months/weeks ago. She stated she notified the Administrator, who said he was busy, and then reported the issue to the Director of Nursing (DON), who told her all residents should report to the Social Service Director. Resident #85 stated no updates had been provided to her or the residents on their missing money and expressed outrage, stating we have rights, and the facility needs to give them their money back. She revealed the specific residents that came to her are Resident #5, Resident #8, Resident #17, Resident #38 but knows were several more due to talk with other residents. Resident #5 On 10/2/25 at 10:38 AM, Resident #5 reported to the SA that \$50 had been taken from him. He stated the money was inside a white envelope in his pants pocket. He believes someone from the laundry department may have collected his pants along with the envelope. He shared that no one has informed him of the outcome or offered reimbursement. While he expressed a desire to have the money returned, he also acknowledged the importance of being more cautious about where he stores his funds. A record review of the email from the Social Service Director to the Administrator on 8/11/25 indicating the resident had reported \$50 missing on 8/8/25. A record review of the admission Record revealed the facility admitted the resident on 3/26/24 with diagnoses including atherosclerotic heart disease. A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/20/25 revealed a Brief Interview for Mental Status score (BIMS) of eleven (11) indicating the resident had moderate cognitive impairment. Resident #8 At 10:41 AM on 10/2/25, Resident #8 explained that he keeps his money in a drawer to save for outings. He noticed that \$40 was missing and reported it to the Resident Council President, who assured him she would notify staff. He stated that no one followed up with him or discussed reimbursement. He expressed feeling uneasy and shared that it would be a blessing if the facility returned the money, as it came from his personal savings. A record review of the admission Record revealed the facility admitted Resident #8 on 9/22/22 with diagnoses including heart failure. A record review of the MDS with an ARD of 8/12/25 revealed BIMS score of 15 indicating the resident was cognitively intact. Resident #17 On 10/2/25 at 8:42 AM, Resident #17 stated that a little over \$100 had been stolen from her some time ago. She reported the incident to a staff member in social services but has not received a response or reimbursement. She expressed sadness that such incidents occur, especially given residents limited financial resources. She added that the experience made her feel unsafe, leaving valuables in her room and that she would greatly appreciate having the money returned. A record review of the statement captured by a staff member dated 6/25/25 confirms resident concern of missing money of \$110. A record review of the admission Record revealed the facility admitted Resident #17 on 3/14/19 with diagnoses including generalized anxiety disorder. A record review of the MDS with an ARD of 7/22/25 revealed a BIMS score of 15 indicating the resident was cognitively intact. Resident #38 On 10/2/25 at 8:52 AM, Resident #38 reported that several weeks prior, she discovered \$87 missing from her purse when preparing to pay for Walmart items delivered by the activities team. Only a \$1 bill and some change remained. She stated that she reported the incident to the council president and two security officers, who assured her they would investigate. As of the interview, she had not received any updates or reimbursement. She expressed feeling deeply discouraged and emphasized that the money was taken without her consent. A record review of the statement given to staff on 6/25/25 confirms that resident stated \$87 was missing from her purse. A record review of the admission Record revealed the facility admitted Resident #38 on 5/2/22 with diagnoses including Anemia. A record review of the MDS with an ARD of 9/8/25 revealed a BIMS score of eight (8) which indicated the resident had moderate cognitive impairment. Resident #81 A record review of the statement made to staff by Resident #81 on 7/7/25 and then again to security personnel that \$15 dollars was stolen from her wallet. A record review of the admission Record revealed the facility admitted Resident #81 on 11/15/22 with diagnoses including</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on interviews and record reviews, and facility policy review the facility failed to ensure that staff reported allegations of verbal abuse involving two (2) of three (3) residents reviewed for verbal abuse (Resident #66 and #93), and failed to report multiple allegations of misappropriation of resident property (money) involving five (5) of 14 residents in Resident Council (Residents #5, #8, #17, #38, and #81) to the State Agency (SA), as required by federal regulations. Findings include:</p> <p>A record review of the facility's policy titled Abuse, Neglect, and Exploitation Policy, revised 8/26/25, revealed: It is the policy of this facility to provide protection of the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, misappropriation of resident property . Reporting/Response 1. All alleged violations will be report to the Administrator and/or the Director of Nursing who will report to the appropriate law enforcement officials when applicable, Mississippi State Department of Health Division of Health Facilities Licensure and Certification and Medicaid Fraud Control Unit/Office of the Attorney General (AGO) within specific timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse.</p> <p>During an interview, on 10/2/25 at 9:31 AM, the Administrator confirmed that multiple residents had reported funds stolen. He stated that, based on available information, the facility determined residents were unable to verify the exact amounts lost, and therefore reimbursement was not provided. However, he acknowledged the facility's responsibility to ensure resident safety and affirmed that if residents had clearly documented the missing amounts, the facility would have been obligated to issue reimbursement either by check or cash, with proof of payment. When asked by the State Agency (SA) why the incident had not been reported, the Administrator responded: I did not know I was supposed to report this to the State Agency. This is my first time dealing with residents having their money stolen.</p> <p>Resident #66</p> <p>On 9/29/25 at 11:43 AM, during an interview, Resident #66 stated that Licensed Practical Nurse (LPN)# 1 raised her voice during the night shift while attempting to administer a newly ordered medication. The resident described the nurse's tone as demeaning and intimidating and stated that she felt talked down to like a child. Resident #66 expressed fear of retaliation, noting concern for other residents who may not be able to speak up.</p> <p>On 9/29/25 at 2:45 PM, during an interview, the resident's roommate (Resident# 94) confirmed the incident, stating the nurse was loud and intimidating, and that her behavior was uncalled for.</p> <p>On 9/30/25 at 3:30 PM, during an interview, Resident #93 described the nurse's tone as rough and intimidating, stating she talks to us like we're kids and throws her weight around. Resident #93 added that such behavior was inappropriate for long-term care.</p> <p>On 9/30/25 at 4:05 PM, during an interview, Certified Nursing Assistant (CAN) #1 reported that LPN 1 was extremely negative, loud, vulgar, and insulting to staff during the same shift. She recalled the nurse saying, Y'all some sorry Mother#####s towards her and other staff, and described her as intimidating to both staff and residents.</p> <p>(continued on next page)</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>Based on observation, interview, record review, and facility policy review, the facility failed to ensure that medications and biologicals were securely stored to prevent access by unauthorized individuals for one (1) of four (4) days of survey. Findings include: A review of the facility's policy titled Controlled Medication Storage Accountability and Proper Destruction Policy, revised 5/17/18, revealed: .2. The outer lock on the medication cart is locked at all times when not in direct view of the nurse. During an observation on 9/29/25 at 11:23 AM, the wound care cart located on the 200 Hall was noted to be unlocked and unattended, with wound cleanser left unsecured on top of the cart. The cart remained unlocked for fifteen (15) minutes, until 11:38 AM when Registered Nurse (RN) #1 arrived, placed the unsecured cleanser inside the cart, and then locked it. During an interview with RN #1 on 9/29/25 at 3:51 PM, she stated the cart should always be locked but explained that the keypad locking mechanism had been malfunctioning, requiring her to use a manual key. She acknowledged that she forgot to lock the cart after her last use. RN #1 also confirmed that the cart contained medications including: Nystatin (antifungal ointment and powder), Santyl (collagenase - enzymatic debriding agent), Dakin's solution (diluted bleach-based cleanser), and other wound care agents. She stated that these medications, if ingested, could cause gastrointestinal distress and would likely result in a visit to the emergency room. In an interview on 9/29/25 at 3:51 PM, the Director of Nursing (DON) confirmed the expectation that all treatment carts remain locked when not in use, citing the potential for harm to residents who may have accessed the wound care products such as Dakin's solution and Santyl. She added that the facility had active hallway traffic, and an unlocked cart could present a risk. In an interview conducted on 10/2/25 at 2:05 PM, the Administrator also confirmed the facility's expectation that carts are to be locked at all times when not in use, and that medications or supplies should not be left on top of the cart.</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>(continued on next page)</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>Based on observation, interview and facility policy review the facility failed to store food and maintain sanitary practices in accordance with professional standards for food safety related to foods not dated, foods not labeled, foods not properly sealed, overly ripe produce and unsanitary handling of ready to eat foods for two (2) of two (2) kitchen observations. Findings include: A review of the facility's policy, Food Safety Policy. Reviewed 08/27/2025, revealed, Policy Explanation and Compliance Guidelines. Facility staff shall inspect all food. Labeling, dating, and monitoring food, including but not limited to leftovers, so it is used by its use-by-date or discarded; and Keeping foods covered or in tight containers. Staff shall adhere to safe hygienic practices to prevent contamination of foods from hands. On 09/29/2025 at 10:30 AM, during an initial kitchen tour and interview with the Food Service Supervisor (FSS) observed Refrigerator #1 had four (4) trays containing prepared individual salads, individual dished out bowls of pudding, and individual dished out bowls of fruit, with no date label, (2) clam shell disposable plates containing, what the FSS identified as the staff's food, with no label and within close enough proximity as to be touching the residents' food, (2) pans of what the FSS identified as blueberry cobbler with no date or label, one (1) plastic container containing fruit cocktail with no date, (1) plastic storage container containing (2) shelled boiled eggs, with a facility Prepared date of 9/18/25 and a facility Use by date of 9/22/25, a container of lemon wedges with a facility Prepared date of 9/24/25 and a Use by date of 9/27/25, (1) opened, pre-filled bag of prepared whipped topping with no opened on date and manufacturer's instructions reading 14 days refrigerated. Refrigerator #3 revealed (1) plastic bin containing raw chicken tenders in a plastic bag, with the lid off the bin and the plastic bag open, leaving the chicken exposed, with no staff presently using the chicken, (1) opened container of cheese slices with the lid opened and the cheese visibly dried out, 11 quarts of strawberries that contained fruit with white bio-growth, three (3) oranges that were overly ripe, soft and pliable to the touch, (1) unopened container of prechopped onion with no date. An observation of the dry bins revealed the lids for bins containing sugar, rice and cornmeal were pushed back leaving the food exposed. An observation of the pantry revealed (1) opened bag of grits with the bag folded down and not securely closed. The FSS acknowledged the deficient storage and labeling concerns in the kitchen. The FSS noted it is his responsibility to ensure the safety of the kitchens' food supply. The FSS reported that the kitchen staff are in-serviced on food safety twice a month. The FSS noted he will implement a system for getting together with the kitchen staff and doing rounds to ensure food storage is done correctly. On 09/30/2025 at 10:20 AM, during a second tour of the kitchen an observation of the lower shelf of the beverage prep area revealed an opened bottle of lemon juice with the manufacturer's instructions that read Refrigerate after opening. No staff were currently preparing beverages at the time of this observation. An observation of the food services line revealed the Dishwasher picking up several pieces of cornbread with her gloved hand and placing them on residents' plates. An observation of the Food Server (FS) revealed she used her gloved hand to move bread on a resident's plate. The FS was also observed using her fingers to push noodles back into a bowl of chicken noodle soup. An interview with the dishwasher revealed she affirmed that she picked up the bread with her gloved hand. The dishwasher revealed she knew not to do this but forgot. The dishwasher reported the importance of not touching ready to eat food with hands is prevent contamination. The dishwasher reported that the kitchen staff are in-serviced every 6 months on food safety. The FS acknowledged touching food on the resident's plates with her gloved hand. The FS affirmed that the reason for not doing this is to not spread germs. The FS stated the staff are in-serviced on food safety 2x a month. The FSS acknowledged the improperly stored lemon juice and confirmed that it is normally kept on the shelf in the beverage prep area. The FSS also acknowledged the two staff members touching ready to eat foods with their gloved hands. The FSS stated his expectation is to have all kitchen staff receive certification in food safety. The FSS reported that he expects the staff to serve residents the best they can. On 10/02/2025 at 11:58 AM, during an interview the Administrator acknowledged the improperly stored foods, exposed foods, and unsanitary handling of ready-to-eat foods. The Administrator noted it is the responsibility of all kitchen staff to maintain food quality and sanitation. The Administrator stated he expects the kitchen staff to date and label foods appropriately, monitor and throw away expired foods, and keep foods covered to eliminate the risk of exposure to debris falling into the food. The Administrator reported that he expects the kitchen staff to follow food service standards.</p>		