STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255262	A. BUILDING _____ B. WING _____	C 04/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURELWOOD COMMUNITY LIVING CENTER	1036 WEST DRIVE LAUREL, MS 39440

(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) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey and Complaint Investigations from 3/16/21 to 3/19/21. During the survey, the SA determined the facility was not in compliance with Requirements for Participation Medicare and Medicaid and cited regulatory deficiencies F602, F677, F759, F812, and F919 were cited at a "D". The following complaints were investigated:CI MS #17469 related to answering call light and CI MS #17472 related to missing narcotic medications was substantiated. CI MS #17582 related to missing hearing aids and dentures, CI MS #17657 related to falls, neglect, improper incontinent care and CI MS#17515 related to missing items/disrespectful to residents was unsubstantiated. The facility has a license for 60 beds with a census of 44. After Administrative review, the original annual survey of 03/16/2021-03/19/2021 was extended on 03/29/2021-04/02/2021, in order to re-evaluate the complaint investigations CI MS #17469. The (SA) substantiated the complaints for Resident Call System(s). During the extended survey, the SA found that the facility was not in compliance with the Requirements for Participation in Medicare and Medicaid and cited regulatory deficiencies related to the complaints, CI MS #17469 was sited at F919. The (SA) identified an Immediate Jeopardy (IJ) that began on 01/09/2021, which was the original date that the complaint, CI MS #17469, alleged the Resident Call System (s) were not answered timely. The facility's failure to provide supervision and to	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/07/2021

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F 000	Continued From page 1 devise appropriate monitoring and surveillance for all residents while the resident call system was malfunctioning was likely to cause harm, injury, impairment, or death. The noncompliance with the monitoring and surveillance of the resident call system and the nursing station/desk subsequently constituted the Immediate Jeopardy (IJ). On 03/30/2021 at 9:30 A.M., the (SA) notified the facility Administrator and the Director of Nursing (DON) of the (IJ) and the IJ template was provided to the facility Administrator. (IJ) existed at: 42 CFC(s) 483.90 (g)(1)(2) -Resident Call System, (F919), Scope and Severity "K". The facility submitted an acceptable Removal Plan on 03/31/2021 at 5:00 P.M., in which the facility alleged all corrective actions were completed on 3/31/2021, and the (IJ) removed on 03/31/2021 at 5:00 P.M. The SA validated the facility's Removal Plan on 4/2/2021, and determined the IJ was removed on 03/31/2021, prior to exit. Therefore, the scope and severity for 42 CFR(s) 483.90 (g) (1)(2) -Resident Call System, (F919) was lowered from "K" to a scope and severity of "E" while the facility develops and implements a plan of correction and monitors the effectiveness of the systematic changes to ensure the facility sustains compliance with regulatory requirements.	F 000		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12	F 602		5/28/21

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F 602	Continued From page 2 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review the facility failed to secure 21of 90 discontinued pain medications (Norco) for one (1) of five (5) closed resident reviews. Resident #248. The facility policy titled "Disposal of Medications From Deceased Residents" dated June 3, 2010 revealed: "Any medications remaining after a resident is deceased will be destroyed. Ownership of all medications issued to a resident are the property of that resident. That ownership may not be transferred to any other individual or entity. It may not be given to charitable organizations or family members. It must be destroyed as would any other discontinued medication." The facility policy titled "Medication Destruction" dated February 16, 2018 revealed", Discontinued medications and medications left in the facility after a resident 's discharge, which do not qualify for return to the pharmacy for credit, are destroyed. Controlled substances are retained in a securely locked area with restricted access until destroyed." The facility policy titled "Controlled Medication Disposal" dated June 3, 2010 revealed "Medications included in the Drug Enforcement	F 602	1. On 12/30/2020 a staff RN brought narcotics to the Director of Nursing for destruction. On 12/30/2020 the DON notified the Administrator of the discrepancy for the missing narcotic count. The Administrator then notified the Regional Director of Operations on 12/30/2020; On 12/30/2020 The DON notified the Regional Nurse Consultant. 12/30/2020 The Director of Nursing (DON) verified with narcotic count and found that 21 of resident #1 Norco 5 mg tablets were missing. Resident #1 received this medication prescribed as needed with the last request being on January 03, 2021. Resident #1 did not miss a dosage and no adverse effect was noted. Resident discharged to the hospital 01/05/2021 and did not return to the facility. On 12/30/20 the Director of Nursing drug tested nursing staff on duty and all nursing staff tested negative. On 12/31/2020 the Administrator notified enforcement and State Agency of the missing 21 Norco 5 mg tablets. On On 12/31/2020 the Administrator and DON completed a full medication audit with count back. The DON and Regional Nurse Consultant completed a medications orders audit on 12/31/2020. No other	

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F 602	Continued From page 3 Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal, and record keeping in the facility in accordance with federal and state laws and regulations. The Director of Nursing and the Consultant Pharmacist are responsible for the facility's compliance with federal and state laws and regulations in the handling of controlled medications. Only authorized licensed nursing and pharmacy personnel have access to controlled medications. Controlled medications remaining in the facility after a resident has been discharged, or the order discontinued, are disposed of by the Director of Nurses or RN designee and Licensed Pharmacist." The facility policy titled "Discontinued Medications" dated June 3, 2010 revealed, "When medications are discontinued by a prescriber, a resident is transferred or discharged and does not take medications with him/her, or in the event of a resident's death, the medications are discontinued and destroyed, or if the packages are unopened, returned to the issuing pharmacy as allowed by state regulations. Medications awaiting disposal or return are stored in a locked secure area with limited access (ex. Director of Nurses Office) designated for that purpose until destroyed or picked up by pharmacy. Medications are removed from the medication cart upon receipt of an order to discontinue (to avoid inadvertent administration)." Interview on 3/16/21 at 11:30 AM, with the facility Administrator (ADM) revealed that the facility Pharmacy Consultant had pin- pointed the nurse that had taken the 21 Norco (controlled pain medications). The nurse was terminated and upon termination the facility discovered the nurse	F 602	discrepancies were found. The Pharmacy Consultant completed a facility audit on 01/08/2021. Pharmacy recommendations were to discuss further at QAPI. The Administrator conducted an In-service "Misappropriation and Exploitation" on 02/06/2021. Discussed on 02/26/2021 at QAPI, no recommendations were made. 2. The facility recognizes that all residents has the potential to be affected by the deficient practice. 3. On 12/31/2020 the Director of Nursing conducted an in-service "Narcotic Count on Med Cart". The following policies were utilized for that education: Physician Orders, Medication Orders, Automatic Stop Orders, Standing Orders, Controlled Medication Disposal, Discontinued Medications Medication Destruction, and Disposal of Medications from Deceased Residents. The Missing Narcotic investigation was reviewed in the QAPI meeting for the month of January with recommendations. Recommendations were to consult to the Regional Nurse Consultant for further guidance. On 05/19/2021 the Administrator will conduct an in-service/education training for all employees to review the policy and procedures for Free from Misappropriation/Exploitation. No employee will be allowed to work until they have been in-service on this policy. On 05/19/2021 the Director of Nursing will conduct an in-service/education on	

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F 602	Continued From page 4	F 602		

had been terminated for taking controlled medications from other nursing facilities prior to the incident of 12/30/20. The ADM stated that the former facility Director of Nurses (DON) had called in the event to the State Board of Nursing after they discovered the nurse that took the medications. ADM stated that they later found out that the nurse had not been called in to the State Board of Nursing prior to the incident of 12/30/20.

Observations on 3/18/21 at 8:58 AM, of the nursing station and the hallways for rooms #1-#31 revealed there was no facility staff attending the nursing station during the observations. While observing the nursing station, the Activities Director (AD) entered the code to the medication room door and went inside and obtained a basket of cigarettes. The AD was not attended by licensed nursing staff while in the medication room.

Observed nursing station from 8:58 A.M.-11:30 A.M. on 3/18/21, and there was not a staff member at the nursing station for 152 minutes (2.5 hours).

Interview on 3/18/21 at 9:00 AM, with Licensed Practical Nurse (LPN) #1, confirmed that the AD is not a licensed nurse and that only licensed nurses have access to the medication room. She confirmed that the AD has access because he has to get the cigarettes to take residents to smoke. LPN#1 stated that she would talk to the AD about him having access to the medication room. LPN#1 stated that there were no controlled medications kept in the medication room. LPN #1 stated that all controlled medications were kept on the medication carts

"Narcotic Count on Med Cart". The following policies were utilized for that education: Physician Orders, Medication Orders, Automatic Stop Orders, Standing Orders, Controlled Medication Disposal, Discontinued Medications Medication Destruction, and Disposal of Medications from Deceased Residents. No nursing staff will be allowed to work until they have been in-service on these policies and procedures. Any deficient practice will be corrected immediately if there is a finding of a deficient practice.

The Regional Nurse Consultant will give instruction to the Director of Nursing on 05/20/2021 on the three way match back system. The DON and designated nursing staff will conduct a monthly three way match back when new orders have been received; 0n 05/25/2021 the Medical Records nurse will print the orders for the upcoming month of June with the DON directing the three way match back. This will continue monthly with no end date.Any deficient practice will be corrected immediately if there is a finding of a deficient practice.

The following policies and procedures: Physician Orders, Medication Orders, Automatic Stop Orders, Standing Orders, Controlled Medication Disposal, Discontinued Medications Medication Destruction, and Disposal of Medications from Deceased Residents. No nursing staff will be allowed to work until they have been in-service on these policies and procedures were reviewed by the

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F 602	Continued From page 5 and are not in the medication room. Observation on 3/18/21 at 10:14 AM, with Registered Nurse (RN)#5 revealed there were no controlled medications in the medication room that were not under a separate lock. A controlled medication lock box was located in the medication room under a separate lock. In an Interview on 3/19/21 at 8:00 AM, with the AD stated that he had been an employee for ten (10) years and no one had ever made any mention of his having access to the medication room. AD stated that he had been the AD for two (2) years and he had been going in and out of the medication room for 2 years to obtain the residents cigarettes. AD did confirm that he was not a licensed nurse. AD stated that from now on he would keep the resident cigarettes in his office and turn them in at the end of the day to the nurses to lock in the medication room. Record review of the facility investigation revealed that the missing medications were 21 Norco. Investigation was completed by the former DON and she determined that LPN#2 was terminated for not counting the controlled medication and 21 Norco were missing for one resident. Interview with the facility ADM on 3/19/21 at 9:30 AM, revealed that the medication counts for the controlled medications were not completed as per the facility policy and with Standards of Practice. She stated that the former DON was a new DON and she had never worked in a nursing home prior. The ADM stated that the former DON had not supervised the staff as they needed and that she was not receiving the controlled medication	F 602	Regional Director of Operations, Regional Nurse Consultant and Administrator and found that the policies were sufficient. No changes were recommended. 4. The Director of Nursing and the Administrator will review the signed narcotic sheet 3x a week for a month and then 1x a week for a month to ensure the narcotic count has proper count to begin May 20, 2021 with completion date of June 20, 2021 and once every two weeks for one month beginning June 20, 2021 and ending July 20, 2021 and once a month therefore for the next six months ending November 20, 2021. The monitoring completed under this POC is submitted to the QAPI Committee for review and follow-up. This plan has a completion date of 05/19/2021. Any deficient practice will be corrected immediately if there is a finding of a deficient practice. *The Regional Nurse Consultant will give instruction to the Director of Nursing on 05/20/2021 on the three way match back system. The DON and designated nursing staff will conduct a monthly three way match back when new orders have been received; The Medical Records nurse started a process as of 05/20/2021 in which the Medical Records nurse will print the orders for the upcoming month of June with the DON directing the three way match back. This will continue monthly with no end date. Any deficient practice will be corrected immediately if there is a finding of a deficient practice.	

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F 602	Continued From page 6 for destruction. The former DON is no longer employed at the facility. None of the nurses involved were currently employed. ADM confirmed that the medications were not destroyed after a resident left and the 21 Norco were left on the medication cart and not accounted for which led to them missing. The count had not been done properly and the nurses had not given the controlled medication to the DON for destruction as per the policy and procedure. Interview on 3/19/2021 at 1:00 PM, with the former DON via telephone revealed that the discarded medications for only one (1) resident was involved in the incident of 21 missing Norco. The former DON stated that she completed the investigation and called the State Board of Nursing to report LPN#2. Former DON stated that the discarded Norco had not been destroyed and were locked in the DON's office. Former DON stated that one resident had 90 Norco (30 per card with 3 cards). DON stated that 21 Norco were unaccounted for and were missing for one (1) resident. On 3/19/2021 at 1:30 PM, the discontinued Noro were observed in the DON's office to be under lock and key. The current DON confirmed through interview that the nurses had not followed the facility's policy and procedure for counting and destroying discontinued controlled medications. The current DON provided copies of the packages of Noro related to the missing 21 Noro of 12/30/20. The observation confirmed that there had been 90 original Noro for one (1) resident and that 21 Moro were unaccounted. Interview on 3/19/21 at 1:40 PM, with the facility	F 602	*Quality Assurance team will meet and discuss during May QAPI meeting for quality and review and communicate findings (if any) to management and administration. Quality Assurance will require necessary staff in-services upon findings beginning 3/16/2021 with a completion date of 05/21/2021.	

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F 602	Continued From page 7 Consultant Pharmacist revealed that he had been to the facility to assess the medications of all residents but that he had not destroyed any medications due to the absence of a DON. He confirmed that he was aware that one resident had 21 Moro out of 90 to be missing. Record review of the controlled medication documentation sheets revealed that the nursing staff had not followed the facility policy and procedure for documenting with two (2) licensed nurses signatures at the beginning and at the end of each shift. The facility self reported complaint CI MS #17472 was substantiated for missing medications of one resident.	F 602		
F 919 SS=K	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility policy it was determined that the facility failed to ensure that all parts/entities of the resident call system were functioning properly for 31 of 44 resident call systems observed. The resident call system was not monitored at the nursing station/desk and did not sound with audio signaling at the nursing	F 919	1. On 03/30/2021 Maintenance Director changed the light bulbs for Resident #12, #14, #17, #18, #22, #5, #7, #9, #15, and #16. On 03/30/2021 The residents above were given bells and whistles immediately to ring while the call-light system was malfunctioning. *On 03/30/2021 American Fire Systems	5/28/21

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F 919	Continued From page 8 station panel/board for 31 resident rooms (resident rooms 1-31). There was no facility staff observed at the nursing station/desk from 7:45 A.M. - 11:30 A.M. on 03/18/2021. The facility's failure to provide supervision and to devise appropriate monitoring and surveillance for all residents while the resident call system was malfunctioning was likely to cause serious harm, injury, impairment, or death. The noncompliance with the monitoring and surveillance of the resident call system and the nursing station/desk subsequently constituted the Immediate Jeopardy (IJ). The State Agency (SA) identified an Immediate Jeopardy (IJ) that began on 01/09/2021, which was the original date that the complaint, CI MS #17469, alleged the Resident Call System(s) were not answered timely. On 03/30/2021 at 9:30 A.M. the (SA) notified the facility Administrator and the Director of Nursing (DON) of the (IJ) and provided the IJ Template to the Administrator. (IJ) existed at: 42 CFR 483.90 (g)(1)(2)-Resident Call System, (F919). The facility submitted an acceptable Removal Plan on 03/31/2021 at 5:00 P.M. in which the facility alleged all corrective actions were completed on 3/31/2021, and the (IJ) removed on 03/31/2021 at 5:00 P.M. The (SA) validated the facility's Removal Plan on 4/2/2021, and determined the IJ was removed on 03/31/2021, prior to exit. Therefore, the scope	F 919	was contacted and then American Fire Systems placed Laurelwood on route to further investigate malfunctioning call light system. *On 03/30/2021 an Emergency QAPI meeting was conducted to address the malfunctioning call light system. The following were in attendance: Medical Directors, MDS RN, MDS LPN, Business Office Manager, Therapy Director, Medical Records, Dietary Manager, Social Services Director, Environmental Service Manager, Regional Maintenance Director, Regional Director of Operations, Regional Nurse Consultant, Community Relations Coordinator, Director of Nursing, and Administrator. Call light policy was reviewed and no changes were made. No staff member is permitted to work until they have been in-service on call light system. 2. All the residents have the potential to be affected by this alleged deficient practice. 3. The call light system was replaced on 05/17/2021 by American Fire Systems. The Administrator and Director of Nursing in-serviced ALL staff to answer CALL-LIGHTS promptly on 05/19/2021. 4.The Maintenance Director began audits on 03/16/2021 and will complete audits 3x's a week for a month then 1x a week to ensure the new call light system is functioning correctly. Any issues noted will	

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F 919	Continued From page 9 and severity for 42 CFR(s) 483.90 (g) (1) (g) (2) -Resident Call System, (F919) was lowered from "K" to a scope and severity of "E" while the facility develops and implements a plan of correction and monitors the effectiveness of the systematic changes to ensure the facility sustains compliance with regulatory requirements. Findings Include: Record review of the complaint information for CI MS #17469 revealed the complaint alleged that the call lights were not answered timely when residents rang for assistance and that the nursing station at the facility was not attended by staff. Review of the facility policy titled "Call Light Use Of", Current Revision Date: November 15, 2019, read: It is the policy of this facility to have an adequately equipped communication system that allows residents to call for staff. All personnel should be aware of call lights at all times. In the event the primary call light system fails to function properly, the facility will have a backup call system in place. The backup system will be of a manner to include audible and/or visual notification of the need of assistance. Backup systems may include but not be limited to bells, horns, and any other device that a resident can use based on their physical capabilities to alert staff. The facility will routinely inspect: The functionality of the call light system to ensure the system is working properly. Record review revealed complaint, CI MS #17469, for a facility resident that alleged she had called the facility numerous times on 01/09/2021 and could not obtain an answer to the call system and/or the facility nursing station.	F 919	be reported to the Administrator and will be corrected immediately. *Quality Assurance team met and discussed during April QAPI meeting for quality and review and communicate findings (if any) to management and administration. Quality Assurance have required necessary staff in-services upon findings since 3/16/2021. Will continue to monitor x 6 months.	

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F 919	Continued From page 10	F 919		

Interview on 03/19/2021 at 11:00 A.M. with complainant for CI MS #17469, revealed that Resident
#245 had a personal cell phone and that the resident had attempted to call the facility nursing station when her call system was not answered on 01/09/2021. Complainant stated that the facility would not answer the call lights timely and resident laid in a dirty brief for over two (2) hours. Complainant stated that she telephoned the facility over and over and no one would answer the telephone, so she got in her car and drove to the facility to get staff to change the resident. Complainant (CI MS #17469) stated that resident was only in the facility for about a week and because of the issues of not answering the call lights and telephones at the nursing station and not changing and assisting resident in a timely matter, they decided to move the resident to another facility.

Record review of the discharge Minimum Data Set (MDS) dated 01/11/2021, revealed that Resident # 245(CI MS #17469) had an admission date of 12/31/2020. There was no Brief Interview of Mental Status (BIMS) score obtained for this resident (CI MS #17469) for the short period of facility stay.

All call lights in the building were checked on 03/18/21 between 7:45 A.M.-11:30 A.M., by the SA and found that the resident call system was malfunctioning. The resident call system for 31 resident rooms (rooms #1-#31) did not sound with audio signaling at the nursing station. No one was at the nursing station/desk to answer the telephone and/or to monitor the resident call system. Resident rooms #12, #14, #17, #18 and

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#22 did not light up above the resident's doors. Resident rooms #5, #7, #9, 15, and #16, call system did not light up at the nursing station. During observtion Registered Nurse (RN #2) was in the area of the nurses station and rooms #12, #14, #17, and #18. Observations revealed 8:58 AM to 11:30 AM that the light for room #14 continued to light up at the nursing station with no one answering for 152 minutes (2.5 hours).

Interview and observation on 03/18/2021 at 11: 30 A.M. with RN#2 confirmed that the nursing station had a light signaling for resident room #14 and the light over the door of room #14 was not signaling/working. RN#2 stated that she had been working part time at the facility for three (3) weeks and she had not noticed this issue prior to 03/18/2021. RN#2 went with surveyor to resident room #14 and verified the light above the door was not working. RN#2 confirmed that the audio sound at the nursing station was not signaling for resident room #14. RN#2 confirmed that the resident in room #14 was a dialysis resident. RN#2 stated that the telephones at the nursing station were not available to the nursing staff during the time that they were delivering care and during medication administration. RN#2 stated that the nursing staff could not run back and forth to the nursing station to answer telephones. RN#2 stated that there was no assigned staff for monitoring the nursing station and for answering the telephones and that she had requested a cordless telephone for the medication carts.

Interview on 03/18/2021 at 11:30 A.M., with Maintenance Manager (MM) revealed that he had been working at the facility for one and a half years as Maintenance Manager. He verified the

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call lights were not working properly for room #14. He donned PPE and went in room #14 and repaired the call light. MM stated "a wire was loose." MM also confirmed that the call lights for resident rooms #17 and #18 were not working properly. MM stated that the resident call system board/panel at the nursing station was broken between room #17 and room #18.

Interview and observation on 03/18/21 at 11:30 A.M., with Resident #92 revealed that he was in his bed and had catheter tubing in bed with him as surveyor entered his room to check his call light operation. Resident #92 stated that he had been waiting for a long time for someone to come and finish helping him with his catheter. Resident #92 stated that last night (03/17/21) he rang his call light for hours (three (3) to five (5) hours) for assistance and never could get any one to come help him. Resident #92 was in room alone with no roommate on 03/18/21.

Record review of the Face Sheet revealed that resident #92 had an admission date of 03/10/2021 and had admission diagnoses of Type 2 Diabetes Mellitus; Obstructive Sleep Disturbance; Essential (Primary) Hypertension; Weakness; Epilepsy; Metabolic Encephalopathy; Lack of Coordination; Weakness; Chronic Kidney Disease; Long Term (Current) Insulin Use; Chronic Respiratory Failure; and numerous other diagnoses. The Minimum Data Set (MDS) dated 3/17/2021 revealed a Brief Interview of Mental Status (BIMS) of 09 which indicated some moderate cognitive deficits. Record review revealed that resident #92 was to be discharged from the facility on 03/19/2021.

RN #2 was back and forth making emergency

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calls from 10:00-10:30 A.M. arranging for admits to the hospital per doctor's orders. The physician was observed in the facility making rounds and issuing orders for resident care. Resident Room #18's call system was observed not to light above the resident's door. Resident room #14 was observed to be signaling visually with a light at the nursing station but was not signaling above the resident's door. There was no auto sound signaling at the nurses station for resident rooms 1-31.

Interview on 3/19/21 at 9:50 A.M., with Resident #92 revealed that prior to yesterday it was difficult to get staff assistance when call system was used. Resident stated that he had been here for 10 days and that up until yesterday when he used the call system it would take more than an hour to get assistance. He stated that he slept better last night and was checked on regularly through the night last night, which had not occurred until yesterday when the call system was repaired.

EXTENDED SURVEY 03/30/2021-04/02/2021

The State Agency (SA) re-entered the facility for the Extended Survey on 03/30/2021 and relayed to the Director of Nursing (DON) and the facility Administrator (ADM) that an Administrative Review had identified an Immediate Jeopardy (IJ) for the Resident Call System (s) not properly functioning at all entities. The (SA) gave the DON and ADM the IJ Template at 9:15 A.M. on 3/30/21.

Observation on 3/30/21 at 9:20 A.M., the SA toured all 44 of the Resident rooms in the facility and engaged all resident bedside call systems. The resident call system/ lights that were not

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working at all entities on 03/30/21 were resident rooms #2; #8; #9; #22; and #24. Room #2 was not in use for residents.

Observations on 03/30/2021 from 9:30 A.M.-10:30 A.M. revealed that there was no alternative resident call systems at the resident bedsides. There were no bells, whistles, horns, or call devices observed for any of the 44 resident rooms in the facility.

On 3/30/2021, at 9:53 AM, the State Agency (SA) activated the call light for Resident # 4. The light was visible outside the resident's door and the sound was audible at the nursing station. The light for the activated call light did not light up at the nursing station.

Interview on 3/30/2021 at 10:30 A.M., with the Maintenance Manager (MM) revealed that resident room #2 was "closed off" for the past 4-5 days due to the fact that the call light was not operable at any entity. He stated he had to take the call lights apart in room #2 to repair Resident's call light in resident room #4. MM confirmed that the call system in room #2 was not operable. MM stated that he had placed a call in to the Regional Director of Maintenance (RDM) for his assistance with the repairs. MM stated that the Regional Director of Maintenance (RDM) had been contacted and he was "suppose" to be on his way to the facility to repair the resident call system. MM stated that he had called a local call system repair company to come out on 03/18/2021 to repair the call system. The MM stated that this local company was the company who they always call when call system repairs were needed. The MM confirmed that he was in the process of repairing the call system. MM

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confirmed that currently the call system was not functioning properly at all entities. MM observed, along with surveyors, and verbally confirmed that resident Rooms #2; #8; #9; #22; and room #24; were not working at all entities on 03/30/2021 at 10:30 A.M.

Interview on 03/30/2021 at 10:43 A.M. via telephone with the local call system repair Company's Representative revealed that the Company was called on 03/18/21 to come to the facility to repair the call system due to no audio sound working at the nursing station. Company stated that the (RDM) was also on the scene and that the (RDM) discovered that the wires for the audio/sound at the nursing station panel was not working and the wires had to be replaced in order to make it sound. (RDM) had repaired the sound at the nursing station and told the local Company that there was no other need for repairs at that time. The local Company Representative stated that the system was not complicated and could be repaired by a good maintenance worker and/or a local electrician. Company Representative stated that to his knowledge his Company had not been to the facility to repair the resident call system in over two (2) years.

Observation and Interview with Maintenance Manager (MM) on 03/30/2021 at 11:10 A.M., of call system for resident room #8 revealedthe call system would not light at the nursing station on the panel/board. MM confirmed that the bulb on the panel/board at the nursing station had a short in it and would not visually light up.

In an interview on 03/30/2021 at 11:45 A.M., with Registered Nurse (RN) #4, she stated that she has not, to date, received any In-service training

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in reference to the resident call system. RN#4 stated that the alternate call system that they put in place was to make rounds on the residents every two (2) hours. The certified staff make rounds every two (2) hours and the licensed staff make rounds on the residents every two (2) hours. This process would make rounds every hour by either certified staff or licensed staff. RN#4 stated that she had no other knowledge of an alternate resident call system other than making rounds every two (2) hours.

Interview on 03/30/2021 at 11:45 A.M., with LPN#2 revealed that she had only been working at the facility for three (3) weeks and she had not attended any In-Services concerning the call system and/or an alternate call system. LPN#2 stated that if the call system was found not to work she would contact Maintenance to report the resident call system. She stated that she had no knowledge concerning an alternate call system to put in place while the resident call system was malfunctioning. LPN#2 stated that to her knowledge there were no bells, whistles, horns, and/or devices placed at the residents' bedside when the call system was malfunctioning.

Observation and Interview on 03/30/21 at 2:30 P.M., of Resident #12 revealed that he was sitting in the dark in his room with a lunch tray in front of him eating. Resident #12 stated that the staff were slow to answer the call system when he used it. Resident #12 stated that "it takes forever" to get someone to answer the call lights. Resident #12 stated that he had been a resident at the facility for about a year and the call lights had always been a problem with staff not answering them timely.

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Record review of the Face Sheet of Resident #12 revealed that he was admitted on 07/09/2020. Minimum Data Set (MDS) dated 01/14/2021 documented a BIMS Score of 15 for resident #12 indicating intact cognitive skills for daily decision making. Resident #12's Face Sheet revealed had diagnoses of Heart Failure, Unspecified; Dependence on Renal Dialysis, and Type I Diabetes Mellitus with Foot Ulcer.

Interview on 03/30/2021 at 2:50 P.M., with the Administrator (ADM), the Nurse Consultant (RN#6), and the Director of Nursing (DON) confirmed that the facility did not have an alternate call system in place on 03/30/21 at 2:50 P.M. There were no bells, whistles, horns or alternate devices placed within the reach of residents to call for assistance while the call system was being repaired. The ADM stated that they had just instituted "15 minute rounds checks" and had devised a rounds report to sign by staff every 15 minutes. The ADM stated that they were currently in-servicing all staff on the resident call system and the alternate resident call system to put in place. The Nurse Consultant (RN#6) stated that she was going to send someone to the store to purchase bells and whistles to put at the resident bedsides as an alternate call system. The Nurse Consultant (RN#6) confirmed that at 2:50 P.M. on 03/30/2021 the facility did not have the alternative devices for the alternate resident call system in place at the facility.

Observations on 03/30/2021 at 2:50 P.M. were made of random resident rooms between rooms #1-#31 and of the emergency kit kept in the medication room. No alternate devices were observed to be in the building and/or at resident bedside and/or within resident reach during the

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malfunctioning of the call system on 03/30/2021. The MM and the RDM along with others were observed to be engaged in the resident call system repair.

In an interview on 03/30/2021 at 3:00 P.M., the MM stated that he had never seen any alternate resident call system devices at the facility. MM stated that they were working hard to get the call system repaired. MM confirmed that as of 3:00 P.M. on 03/30/2021 the facility's resident call system was malfunctioning and repairs were in process.

Observations on 3/30/2021 at 4:30 P.M. revealed that the call system at the nursing station was being repaired by the facility MM.

The facility submitted a Removal Plan on 3/31/2021 for the IJ. Review of the facility's Removal Plan revealed the facility took the following actions to remove the IJ:

Removal Plan:

On March 30, 2021 at 9:30 A.M. State Agency (SA) notified facility Administrator of Immediate Jeopardy (IJ). The SA provided the facility Administrator the IJ template.

Brief Summary of Events

The facility failed to ensure that all components of the Resident Call Light System were properly functioning, and call lights were being answered. There were no staff members monitoring the nurses' station call light system. Failure to ensure a proper call light system could have a serious adverse outcome of serious injury, serious harm,

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serious impairment or death to all residents, and there was a need for immediate action. The state surveyors identified call light malfunctions for rooms #2, 8, 9, 22 and 24. Malfunction being light malfunctioning above door and/or light alert at nurses' station not working.

Corrective Actions:

1. On March 30, 2021 at 9:30 A.M. the Administrator immediately implemented procedures to protect the residents by implementing 15-minute rounding. The facility also assigned (2) Licensed Practical Nurses, (1) Registered Nurse, and (1) Social Services Director to observe mid-way of each unit.

2. On March 30, 2021 Regional Maintenance Director immediately changed bulbs at the nurses' desk on room #2, 8, 9, 22 and 24. On 03/30/21 at 11:55 A.M. Vendor (1) was contacted, and Vendor (1) placed Laurelwood on route to further investigate repairs of system malfunction for clarity and further repairs to room #2 and #24.

3. On March 30, 2021 at 11:30 A.M. a replacement cord was ordered and the wrong part came in, so it was reordered and it is scheduled to arrive to the facility on April 1, 2021 for room #2.

4. On March 30, 2021 an Emergency Quality Assurance Performance Improvement meeting was called for review and discussion of the cited Immediate Jeopardy at 12:10 P.M. The call light policy was discussed and found sufficient; no corrections needed. The back-up/alternate system was discussed, the repairs and malfunction of the call light system was presented

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by Regional Maintenance Director with the following staff in attendance and the Medical Director via phone, Administrator, MDS Registered Nurse Coordinator, MDS Licensed Practical Nurse Coordinator, Director of Nursing/Infection Preventionist, Maintenance Director, Medical Records Coordinator, Rehabilitation Director. Dietary Manager, Housekeeping Supervisor, Regional Director of Operations, and Regional Nurse Consultant. Recommendations were made on all findings for process of starting a plan of corrective action.

5. On March 30, 2021 at 1:00 P.M. a staff member was assigned to the nurses' station and will be continued until call light system is working properly.

6. On March 30, 2021 at 2:00 P.M. an in-service was conducted by the Regional Nurse consultant for direct (11) and non-direct care staff (11) to include the call light process and back up procedures on March 30, 2021.

7. On March 30, 2021 Vendor one (1) arrived at 3:43 P.M. to further investigate the call light system.

8. On March 30, 2021 at 3:45 P.M. the back-up system was implemented which includes calls bells and whistles for residents to utilize to call for assistance.

9. No staff will be allowed to work until in-serviced on call-light policy and procedures.

10. The facility alleges the Immediate Jeopardy (IJ) was removed on March 31, 2021 at 5:00 P.M.

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The SA validated on 04/02/2021, that all corrective actions had been taken by the facility to remove the IJ during the extended survey on 03/30/2021-04/02/2021, and the IJ was removed on 03/31/2021 at 5:00 P.M.

The State Agency (SA) validated the facility's approved Removal Plan on April 2, 2021 as follows:

1. On March 30, 2021 at 9:30 A.M. the Administrator immediately implemented procedures to protect the residents by implementing 15-minute rounding. The facility also assigned (2) Licensed Practical Nurses, (1) Registered Nurse, and (1) Social Services Director to observe mid-way of each unit. Validations were completed by the SA on 04/02/2021, through interviews, observations, and record reviews, that the facility had assigned specific staff including one (1) Registered Nurse (RN), two (2) Licensed Practical Nurses (LPN's), one (1) Social Worker, one (1) Activity Director, and four (4) Certified Nursing Assistance (CNA's), to complete and document the 15 minute rounds for each of the residents in the facility.

2. On March 30, 2021 Regional Maintenance Director immediately changed bulbs at the nurses' desk on room #2, 8, 9, 22 and 24. On 03/30/21 at 11:55 A.M. Vendor (1) was contacted, and Vendor (1) placed Laurelwood on route to further investigate repairs of system malfunction for clarity and further repairs to room #2 and #24. The SA validated on 04/02/2021, through interview, observation, and record review that the Regional Maintenance Director and the local maintenance Vendor were in the facility making the repairs to the resident call system.

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3. On March 30, 2021 at 11:30 A.M. a replacement cord was ordered and the wrong part came in, so it was reordered and it is scheduled to arrive to the facility on April 1, 2021 for room #2. The SA validated on 04/02/2021, through observation, interview, and review of maintenance invoices that repair parts were ordered for the repair and/or replacement of the resident call system in the facility.

4. On March 30, 2021 an Emergency Quality Assurance Performance Improvement meeting was called for review and discussion of the cited Immediate Jeopardy at 12:10 P.M. The call light policy was discussed and found sufficient; no corrections needed. The back-up/alternate system was discussed, the repairs and malfunction of the call light system was presented by Regional Maintenance Director with the following staff in attendance and the Medical Director via phone, Administrator, MDS Registered Nurse Coordinator, MDS Licensed Practical Nurse Coordinator, Director of Nursing/Infection Preventionist, Maintenance Director, Medical Records Coordinator, Rehabilitation Director. Dietary Manager, Housekeeping Supervisor, Regional Director of Operations, and Regional Nurse Consultant. Recommendations were made on all findings for process of starting a plan of corrective action. On April 2, 2021 the SA validated through interviews, and record review of the sign in sheet for the Emergency Quality Assurance Performance Improvement meeting, that the committee had met on 03/30/2021 and all were present at the meeting via validation of signatures and validation through interviews.

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	255262	A. BUILDING _____ B. WING _____	C 04/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURELWOOD COMMUNITY LIVING CENTER	1036 WEST DRIVE LAUREL, MS 39440

(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) COMPLETION DATE
F 919	Continued From page 23	F 919		

5. On March 30, 2021 at 1:00 P.M. a staff member was assigned to the nurses' station and will be continued until call light system is working properly. The SA validated on 04/02/2021 through interview and observation that there was assigned staff at the nursing station.

6. On March 30, 2021 at 2:00 P.M. an in-service was conducted by the Regional Nurse consultant for direct (11) and non-direct care staff (11) to include the call light process and back up procedures on March 30, 2021. The SA validated on April 2, 2021 through interviews, and record review of the documented In-Service and sign in sheets that staff at the facility had been In-Serviced on the resident call system and the process for implementing a back up plan.

7. On March 30, 2021 Vendor one (1) arrived at 3:43 P.M. to further investigate the call light system. The SA validated on 04/02/2021 through interview and observation that the Vendor was present in the facility to assist with the repairs to the resident call system.

8. On March 30, 2021 at 3:45 P.M. the back-up system was implemented which includes calls bells and whistles for residents to utilize to call for assistance. The SA validated through observation, and interview, on 04/02/2021, that each resident bedside had been equipped with a back-up devise of a bell and/or a whistle, for use in case the resident call system filed.

9. No staff will be allowed to work until in-serviced on call-light policy and procedures. The SA validated on 04/02/2021 through interviews and review of the In-Service meeting records and sign in sheets, that no employee would be allowed to

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	255262	A. BUILDING _____ B. WING _____	C 04/02/2021

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F 919	Continued From page 24 work until they were In-serviced on the resident call system and back up plan. 10. The facility alleges the Immediate Jeopardy (IJ) was removed on March 31, 2021 at 5:00 P.M. The SA validated through record reviews, interviews, observations, and through hands on testing of each resident call system that the IJ was removed as per the facility's approved Removal Plan on March 31, 2021 at 5:00 P.M. The SA validated on 04/02/2021, that all corrective actions had been taken by the facility to remove the IJ during the extended survey on 03/30/2021-04/02/2021, and the IJ was removed on 03/31/2021 at 5:00 P.M.	F 919		