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 _____	04/02/2021

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

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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 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry	F 677		5/28/21

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F 677	Continued From page 2 out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, record review and facility policy review the facility failed to provide pericare for one (1) of four (4) observations. Resident # 14. The facility policy and procedure titled "Perineal Care " dated August 25, 2014 revealed, "cleanse the perineum to prevent infection and odor... Place call light in place and instruct resident to call for assistance, if needed. Provide privacy. Provide a clean surface. Perform hand hygiene. Put on gloves. Expose perineal area. Avoid unnecessary exposure. Clean perineal area well with soap and warm water or other cleanser taking care to clean from front to back using a clean cloth or clean area of the cloth for each stroke. 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). Dry perineal area moving from front to back. Use a blotting motion with towel. Turn resident on side. Clean, rinse (as applicable) and dry buttocks and perineal area without contaminating perineal area. Remove wet incontinent pad or protective linen. Change gloves and perform hand hygiene. Place a dry incontinent pad underneath resident. Discard linen properly. Empty, clean and store basin, if used. Dispose of gloves properly. Perform hand hygiene. Reposition resident. Resident # 14 Observation on 3/18/21 at 9:45 AM, of peri-care	F 677	1. 1. On 03/18/2021 Resident #14 was offered a shower after the facility was made aware of the incident, On 03/18/2021 Resident #14 declined the shower but was accepting of a bed bath. On 03/18/2021 The Director of Nursing and Certified Nursing Assistants(CNA) #1 returned to Resident #14 and the Director of Nursing supervised the perineal care of the Resident during the bed bath on 03/18/2021; 2.All Residents have the potential to be affected by this deficient practice. 3.On May 19, 2021 an in-service/education was completed with review of the following policies/procedures: Perineal Care, Daily work assignments, Bed Bath, Activities of Daily Living, Bed pan/urine removal, Catheter care urinary, Abuse/Neglect, Colostomy/Ileostomy care, Infection Control, and Skin care process with all direct care staff; All direct-care staff will be in-service before they are allowed to work. *All certified nursing assistants will complete a skilled competency checklist to be conducted by charge nurse began on 05/19/2021; This will be completed quarterly as part of our infection control and activities daily of living/quality care systems. *A random sample of residents will be	

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F 677	Continued From page 3 being with Certified Nursing Assistant (CNA) #1 on Resident #14. Resident #14's room had a strong urine odor. CNA #1 prepared a clean pad and clean brief to roll under the resident. CNA #1 asked resident to turn to the left. The resident turned and the CNA #1 rolled the soiled brief and pad. CNA #1 then rolled the clean pad and brief under the resident. At this time, CNA #1 asked the resident to turn to the right side. The resident turned to the right side. CNA #1 removed the soiled brief and pad and unrolled the clean brief and pad under resident. CNA #1 secured the clean brief. Prior to applying the clean brief, CNA #1 did not provide any peri care. She changed the brief and pad only. On 3/18/21 at 10:00 AM, in an interview with Resident #14 stated I was wet, but I was not soapy wet. They changed my brief before day this morning. They come and check on me. They keep me changed. They usually wipe me off. On 3/18/21 at 4:50 PM in an interview with CNA #1 stated, "I knew what to do. I was thinking in my mind what to do. I should have done peri care." She stated the resident can get a urinary tract infection, if peri care is not done properly. On 3/19/21 at 5:10 PM, in an interview with Director of Nursing (DON) confirmed CNA #1 should have provided peri care. She stated CNA #1's actions can cause all kinds of problems. It could cause the Resident #14 to get an infection. A record review of Resident #14's Face sheet revealed Resident#14 was admitted on 4/16/20. A record review of Resident #14's Medical Doctor diagnoses included Lack of Coordination, Muscle	F 677	selected for daily rounding beginning 05/17/2021 to observe CNA pericare practice. It will be assigned by the Administrator at four residents per day on a Monday through Friday schedule with feedback from the licensed nurse who has been assigned to observe. 4. The Director of Nursing will do visual audits 3x's a week for a month starting 05/24/2021 for a total of twelve residents; then weekly for a month a total of twelve residents and then random will continue as a quarterly practice sampling twelve residents per quarter to ensure staff are providing peri-care per the guidelines. The results of the monitoring completed under this POC will be submitted to the QAPI Committee for the month of May on 05/26/2021 for review and follow up with recommendations from Director of Nursing.	

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F 677	Continued From page 4	F 677		

Weakness, and Abnormalities Gait and Mobility.

A record review of General Orientation Checklist revealed for CNA #1 revealed her initials on the checklist for the role in resident care.

A record review of the Comprehensive Care Plan for ADL's with an initiation date of 4/30/20 and a revision date of 10/21/20 revealed, " I have an ADL self-care performance deficit related to (r/t) weakness, decreased mobility and seizure disorder. Interventions on the care plan included" personal hygiene limited to total assistance of one, toileting/ Incontinent brief change limited to total assistance of one (1)- two (2)". A care plan for Urinary Tract infection revealed , " I have a history of Urinary Tract Infections with an initation date of 7/13/20 and a revision date of 10/21/20 interventions/task included check frequently for incontinence. Wash, rinse, and dry soiled areas." A care plan for skin with an initiation date of 4/30/20 and a revision date of 7/28/20 revealed " I have potential for impairment to skin integrity due to decreased mobility and incontinence. Interventions/Task included, " Moisture barrier cream to perineal area with each adult brief change Prn (as needed). A care plan for bowel and bladder incontinence with a hisotry of Urinary tract infection with an initation date of 4/30/20 and a revision date of 4/30/20 revealed "Check frequently of incontinence. Wash, rinse, and dry perineum.Change clothes PRN after incontinence episodes."

A record review of the Quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 1/11/21 revealed a Brief Interview for Mental Status (BIMS) score of 15. Section G0110. Activities of Daily Living (ADL) Assistance

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F 677	Continued From page 5 Reveals: Personal hygiene reveals that the resident requires extensive assistance of one person. Section GG0130 Self-Care: Toileting hygiene reveals that the resident is dependent.	F 677		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews, record review, and facility policy review, the facility failed to have a less than five (5) percent med error rate as evidenced by the facility failed to administer oral inhalation medication per manufactures guidelines for two (2) of three (3) medication administration observations Residents # 9 and Resident #11. Findings include: Review of the the facility's, "Oral Inhalation Administration policy", dated November 1, 2008 revealed the purpose is to allow correct administration of oral inhalers to residents, and for instruction in proper techniques for those resident able to administer the medication to themselves. Have resident rinse his/her mouth and spit out the rinse water. Review of the "Trelegy Ellipta Guide", dated May 2019, revealed the possible side effects of Trelegy Ellipta can cause serious side effects including: fungal infection in your mouth or throat	F 759	1.On 03/17/2021 Resident #9 was asked to rinse their mouth out after the facility was made aware of the medication error. The Director of Nursing verbal counseled Licensed Practical Nurse #1 and Registered Nurse #2. On 03/17/2020 Resident #1 and #9 were assessed by a licensed nurse and the results had negative findings. On 03/17/2020 the Director of Nursing gave verbal education to resident #9 and #11 and advised to rinse mouth after oral inhalation. 2. All residents have the potential to be affected by this deficient practice. 3.The DON conducted an in-service training on 05/19/2021 for all nurses to review the policy and procedure for medication administration of inhalers, Physician Orders, Medication Orders, Automatic Stop Orders, Standing Orders, Controlled Medication Disposal, Discontinued Medications Medication	5/28/21

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F 759	Continued From page 6 (thrush). Rinse your mouth with water without swallowing after using Trelegy Ellipta to help reduce your chance of getting thrush. Review of the, "Quick Guide to using Symbicort Inhaler", dated 2018, revealed after you finish taking Symbicort two (2) puffs, rinse your mouth with water. Spit out the water. Do not swallow it. The guide also states Symbicort may case serious side effects including: fungal infection in your mouth or throat (thrush). Rinse your mouth with water without swallowing after using Symbicort to help reduce your chance of getting thrush. Resident #9 A Medication Administration observation on 03/17/21, at 09:15 AM, with Licensed Practical Nurse (LPN) # 1 revealed the nurse failed to instruct Resident #9 to rinse her mouth with water after 2 puffs of Symbicort inhaled orally for Shortness of Breath (SOB). During an interview on 03/17/21 at 11:36 AM, Resident #9 revealed nobody has ever discussed with her to rinse her mouth with water after inhaling Symbicort. Resident #9 said she didn't know she needed to rinse her mouth. In a interview on 03/19/21 at 11:40 AM Interview with LPN #1 confirmed she failed to ask Resident #9 to rinse her mouth after inhaling the Symbicort. LPN #1 said because it was not on the Medication Administration Record (MAR) she did not think Resident #9 should rinse her mouth. LPN #1 also said she knew it could cause a mouth fungus. LPN #1 said Resident #9 has not had a mouth fungus.	F 759	Destruction, and Disposal of Medications from Deceased Residents. The DON will complete a medication pass review on the nursing staff starting 05/24/2021. All medication errors will be handled in accordance with facility policies and procedures. 4.Starting on 03/24/2021 the DON will complete audits 3xs a week for a month and then 1x a week for a month to ensure the nursing staff is administering medication properly. *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.	

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F 759	Continued From page 7	F 759		

Record review of the Face Sheet revealed the facility admitted Resident #9 on 09/26/20, with the diagnoses that included Chronic Obstructive Pulmonary Disease (COPD), Fatigue and Shortness of Breath (SOB). The Admission Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 12/30/20 revealed Resident #9 had a Brief Interview for Mental Status (BIMS) of fifteen (15) that indicated Resident # 9 is cognitively intact.

Resident #11

During a Medication Administration observation for Resident #11 on 03/18/21 at 09:45 AM, Registered Nurse (RN) #2 administered Trelegy Elipta Aerosol 100-62.5/25 mcg/INH (micrograms per inhalation) 1 puff orally. RN #2 failed to instruct the resident to rinse her mouth out with water and spit it out after the medication was administered.

An interview on 03/18/21 at 10:00 AM, with Resident #11, revealed the resident has not been told to rinse her mouth with water and spit it out after using the Trelegy inhaler.

Review of the facility's, "Physicians Orders", dated 4/17/20, revealed Resident #11 is ordered Trelegy Ellipta Aerosol Powder Breath Activated 100-62.5-25 MCG/INH, 1 puff inhale orally one time a day for Chronic Obstructive Pulmonary Disease (COPD).

Review of the facility's, "Physicians orders", dated March 17, 2020 revealed Resident #11 was ordered Nystatin Suspension five (5) milliliters by mouth four times a day for thrush for seven (7)

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F 759	Continued From page 8	F 759		

days.

In a interview on 03/19/21 at 11:56 AM, RN #2 confirmed she failed to ask the resident to rinse her mouth with water and spit it out. RN #2 said that she did not think about it. RN #2 said at the other facility she work at its on the MAR and that reminds her to ask the residents to rinse their mouth.

Record review of the Face Sheet revealed the facility admitted Resident #11 on 4/17/20, with the diagnoses that included Chronic Obstructive Pulmonary Disease (COPD), Shortness of Breath (SOB), Diabetes Mellitus and Emphysema. The Admission Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 1/21/21 revealed Resident #11 had a Brief Interview for Mental Status (BIMS) of fifteen (15) that indicated Resident #11 is cognitively intact.

In a interview on 03/19/21 at 12:08 PM, with Director of Nursing (DON) confirmed the staff should rinse the residents mouth after receiving inhalers with steroids because it could cause a fungal infection in the mouth or throat. The DON said the pharmacy consultant comes twice a month and randomly watch the nurses during their medication administration. The consultant will email recommendations and if the nurse needs further education.

In a interview on 03/19/21 at 12:32 PM, with The Pharmacy Consultant confirmed the nurses should ask the residents to rinse their mouth after using all steroid medications inhaled orally. The Pharmacist said he recommended the facility to add to Resident #11 MAR to rinse her mouth with

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F 759	Continued From page 9 water and spit it out after inhaling the Trelegy Elilipta on July 31,2020 to avoid fungal infections. The Pharmacy Consultant also said he recommended the facility place on the MAR to rinse Resident #9's mouth with water and spit it out on September 29, 2019 and Feb 20, 2020 to prevent fungal infections and the facility did not follow the pharmacy recommendations.	F 759		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based of observation, staff interviews, record review, and facility policy review, the facility failed to remove expired food items from the food pantry and failed to monitor the freezer temperature for one 1 of four 4 observations.	F 812	Facility plan to correct to correct deficiency as it relates to individual (Dietary Manager) in survey was to monitor daily and put individual on probationary period with POC. After in-services were conducted and missed	5/28/21

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F 812	Continued From page 10 Findings include: The facility's policy, "Food Storage", dated 8/18/2011, revealed the "Policy Statement: It is the policy of the facility that food storage areas be maintained in a clean, safe, and sanitary manner...4. Frozen foods shall be stored at minus 18 degrees Celsius (0) degrees Fahrenheit) or below at all times. There is an accurate thermometer in each refrigerator and freezer and in store rooms used for perishable foods." Observation on 3/16/21 at 10:20 AM, during an initial tour of the kitchen, with the Dietary Manager, revealed the freezer thermometer could not be located by the Dietary Manager in the freezer. During the tour State Agency (SA) found a 32 ounce French's Dijon Mustard with an expiration date of 10/5/20 and a box of 500 yellow mustard in individual packs with an expiration date of 2/23/21. On 03/16/21 at 10:40 AM, in an interview with Dietary Manager stated, she just wrote down zero because she could not locate the thermometer in the freezer. She stated the freezer is always zero. when I check it daily. On 3/18/21 at 2:24 PM, in an interview with Dietary Manager stated residents can get sick from eating expired foods It is extremely important to remove expired foods from the shelf. I should have removed them. She stated that by not seeing the thermometer and writing down zero it could cause the residents to get sick. She stated food could defrost and leak on other foods in the freezer and make the residents sick. She stated it could cause food poisoning.	F 812	items continued the individual (Dietary Manager) was removed from the building on 4/21/2021 and position was replaced immediately. 1. On 03/16/2021 a thermometer was placed on the top shelf of the freezer. On 03/16/2021 the Dietary Manager and District Manager audited the refrigerator, pantry, and freezer for all expired foods. No other expired food was found. On 03/16/2021 an in-service was conducted by the Dietary Manager for dietary staff concerning expired foods and missing thermometer in the freezer. 2. All residents have the potential to be affected by this deficient practice. 3. The Dietary Manager and Administrator will check all refrigeration units and the dry goods room for labels/dates on all food items daily beginning 3/16/2021. Dietary Manager in-serviced all staff on 3/16/2021 and will continue to do so monthly and ongoing. 4. The Dietary Manager will check all refrigeration and freezer units for thermometers Monday through Friday beginning 3/16/2021 to ensure we are compliant per our policy. In the case that any food is found expired or without a label the Dietary Manager will discard items immediately. *The Administrator will monitor kitchen sanitation on routine weekly visits to	

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F 812	Continued From page 11 On 3/19/21 at 9:58 AM, in an interview with the Administrator stated, it is critical that expired items be removed and that we do not serve the residents expired food. We need to know the temperature of the food in the freezer before serving it to the residents. Expired foods and not knowing the freezer temperatures can have a critical effect on the residents. A record review of the freezer temperature log revealed a negative zero (0) on 3/16/21.	F 812	ensure in-services are being performed beginning 3/16/2021 utilizing on Kitchen Sanitation Checklist. *Quality Assurance team will meet and discuss during May QAPI meeting for quality and review and communicate findings (if any) to dietary management and administration. QA team discussed in QAPI for the month of April on 04/28/2021. Quality Assurance will continue to monitor and discuss monthly and ongoing.	
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 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.	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 was contacted and then American Fire Systems placed Laurelwood on route to further investigate malfunctioning call light system.	5/28/21

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F 919	Continued From page 12 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 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	F 919	*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 be reported to the Administrator and will be corrected immediately. *Quality Assurance team met and	

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F 919	Continued From page 13 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. Interview on 03/19/2021 at 11:00 A.M. with complainant for CI MS #17469, revealed that Resident	F 919	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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#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 #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

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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 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

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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 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

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#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 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.

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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 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;

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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 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

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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.

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

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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 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.

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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, 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

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

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

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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 by Regional Maintenance Director with the following staff in attendance and the Medical Director via phone, Administrator, MDS Registered Nurse Coordinator, MDS Licensed

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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.

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

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F 919	Continued From page 25 on 03/31/2021 at 5:00 P.M.	F 919		

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.

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

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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.

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

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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 work until they were In-serviced on the resident call system and back up plan.

10. The facility alleges the Immediate Jeopardy

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F 919	Continued From page 28 (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		