STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255262	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/08/2025**

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
K 000	INITIAL COMMENTS The facility must meet the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA).	K 000		
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to provide protect the cooking equipment in	K 324	On 04/14/25 Documentation was provided by Administrator of the cleaning	5/5/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/05/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 324	Continued From page 1 accordance with NFPA 96 Chapter 11 and NFPA 101 section 18.3.2.5.3 (10), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 10.6.2. The deficient practice affected all smoke compartments and residents in the facility on the day of survey. Findings Include: On 4/8/25 at 10:50 AM, observation revealed the facility failed to provide the documentation for the cleaning and inspection of the kitchen hood system. The finding was acknowledged by the Administrator and Maintenance Supervisor verified this observation during the exit interview on 4/8/25.	K 324	and inspection of the kitchen hood system. All residents have the potential to be affected by this practice. Maintenance Supervisor was in-serviced 04/24/25 by Regional Maintenance Director on Life Safety Manual and what documentation is required to have available for the Life Safety Code Surveyor. The Quality Assurance Performance Improvement (QAPI) team met and discussed the adverse event on 05/01/25. The team included Medical Director, Administrator, Director of Nursing, Infection Control Preventionist, MDS Nurses, Medical Records, Therapy, Maintenance, Life Connections, Business office Manager, Dietary Manager and Social Services. The policy was reviewed and no changes were deemed necessary. All inspections including Fire Drills will be brought to the Monthly Quality Assurance Performance Improvement Committee (QAPI) for review 05/01/25. Administrator will review Life Safety Code binder weekly for four weeks then monthly for three months to check for completeness. Any concerns will be brought to QAPI for corrective action.	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier	K 372		5/5/25

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K 372	Continued From page 2 Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on the observation, the facility failed to provide half hour rating in the smoke barrier wall in accordance with NFPA 101 sections 19.3.7.3 and 8.5.6.2. This standard deficiency affected three (3) of three (3) smoke compartments and 43 of 47 residents in the facility on the day of Survey. Findings Include: On 4/8/25 at 9:30 AM, observation revealed unsealed holes around grey data cables and copper piping at the following smoke barrier walls: 1. The South Hall Smoke Wall near resident room #15 2. The North Hall Smoke Wall near resident room #18 These smoke barrier walls were incapable of resisting the passage of smoke throughout the facility. The findings were acknowledged by the Administrator and Maintenance Supervisor	K 372	The South Hall Smoke Wall near resident room #15 was caulked with fire caulking on 04/08/25 by Maintenance Supervisor. The North Hall Smoke Wall near resident room # 18 was caulked with fire caulking on 04/08/25 by Maintenance Supervisor. All residents have the potential to be affected by this practice. All fire walls in facility were checked to assure there was no access by pipe wire, or computer lines without being fire caulked to resist passage of smoke throughout the facility. The Quality Assurance Performance Improvement (QAPI) team met and discussed the adverse event on 05/01/25. The team included Medical Director, Administrator, Director of Nursing, Infection Control Preventionist, MDS Nurses, Medical Records, Therapy,	

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K 372	Continued From page 3 verified this observation during the exit interview on 4/8/25.	K 372	Maintenance, Life Connections, Business office Manager, Dietary Manager and Social Services. The policy was reviewed and no changes were deemed necessary .In-service by Regional Maintenance Director was given 04/24/25 to Maintenance Supervisor on Smoke Walls and the required smoke barrier to resist the passage of smoke throughout the facility. Maintenance Supervisor and/or Administrator will make rounds beginning 04/10/25 weekly times four weeks then monthly times three month to make sure all fire walls have been routinely checked to assure they are sealed to prevent smoke from penetrating wall to other areas.	
K 374 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by:	K 374		5/5/25

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K 374	Continued From page 4 Based on observations, the facility failed to provide 20-minute fire resistance rating smoke barrier door in accordance with NFPA 101 sections 19.3.7.6, 19.3.7.8, 19.3.7.9. This standard deficiency affected two (2) of three (3) smoke compartments and 21 of 47 residents in the facility on the day of the survey. On 4/8/25 at 9:15 AM, observation revealed the North Hall smoke barrier door of the facility did not properly close upon activation of the fire alarm and sprinkler systems. The finding was acknowledged by the Administrator and verified by the Maintenance Supervisor during the exit interview.	K 374	The North Hall smoke barrier door was adjusted 04/08/25 by Maintenance Supervisor to close upon activation of the fire alarm and sprinkler system. All residents have the potential to be affected by this practice. Maintenance supervisor was educated 04/24/25 by Regional Maintenance Director on Life Safety Code requirements including Smoke barrier doors. The Quality Assurance Performance Improvement (QAPI) team met and discussed the adverse event on 05/01/25. The team included Medical Director, Administrator, Director of Nursing, Infection Control Preventionist, MDS Nurses, Medical Records, Therapy, Maintenance, Life Connections, Business office Manager, Dietary Manager and Social Services. The policy was reviewed and no changes were deemed necessary. Administrator and /or Maintenance Supervisor will check all smoke barrier doors weekly for four weeks then monthly for three months beginning 04/11/25 and ending 08/09/25 for proper function upon activation of the fire alarm and sprinkler system,	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and	K 712		5/5/25

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K 712	Continued From page 5 unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to properly perform fire drills as per NFPA section 19.7.1.2.2. This definite affected all 47 residents in the facility on the day of the survey. Findings Include: On 4/8/25 at 10:45 AM, the facility failed to provide the documentation for the Fire Drills for the following dates: 1. 2nd and 3rd shift for the 1st quarter of 2024 2. 1st, 2nd and 3rd shift for 2nd quarter of 2024 3. 3rd shift for 3rd quarter of 2024 4. 1st,2nd,3rd and 4th shift for 4th quarter of 2024 5. 3rd shift for 1st quarter of 2025 The findings were acknowledged by the Administrator and Maintenance Supervisor verified this observation during the exit interview on 4/8/25.	K 712	Maintenance Director was educated on Fire Drills by Regional Maintenance Supervisor 04/24/25. All Residents have the potential to be affected by this practice. Life Safety Book was brought to Administrators office after Quality Assurance Performance Improvement Committee Meeting 05/01/25. Book was reviewed to show Fire Drills will be conducted on one shit per month per quarter. The Quality Assurance Performance Improvement (QAPI) team met and discussed the adverse event on 05/01/25. The team included Medical Director, Administrator, Director of Nursing, Infection Control Preventionist, MDS Nurses, Medical Records, Therapy, Maintenance, Life Connections, Business office Manager, Dietary Manager and Social Services. The policy was reviewed and no changes were deemed necessary. Life Safety book will be reviewed monthly for 6 months beginning 05/01/25 and ending 11/01/25	

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