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	34NH	A. BUILDING: _____ B. WING _____	04/10/2025

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M 000	Initial Comments The State Agency (SA) conducted an annual recertification survey at the facility from 04/07/2025 through 04/10/2025. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirement and cited M500, M620, and M815.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a	M 500		5/5/25

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M 500	Continued From page 1 pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law;	M 500		

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M 500	Continued From page 2 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical	M 500		

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M 500	Continued From page 3 record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level III Based on interviews, record review, and the facility policy review, the facility failed to notify the physician of a resident with no documented bowel movement for six (6) consecutive days, which resulted in the resident being hospitalized on 1/30/25 for evaluation that included findings consistent with fecal impaction for one (1) of 14 sampled residents. Resident #25	M 500	* Resident #25 was reviewed 04/10/25 through the Alert listing report by Director of Nursing and Medical Records with no alerts noted. Physician was notified by the Director of Nursing of residents status. * All Residents have the potential to be affected by this practice.	

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M 500	Continued From page 4 Findings include: A record review of the facility's policy "Notification of Changes in a Resident's Conditions or Status", undated, revealed, " ... It is the policy of this facility to ...consult with his or her physician ...changes in the resident's condition and/or status ...Procedure 1. Nursing services shall be responsible for notifying the resident's attending physician when ...d. There is a need to alter the resident's treatment significantly ..." A record review of the statement provided via the Administrator on facility letterhead dated 4/10/25 revealed the facility did not have a policy regarding constipation or bowel movements. On 04/07/25 at 02:38 PM, during a phone interview with a family member, she explained Resident #25 had been hospitalized in January because she did not have a bowel movement (BM) for a week. On 04/08/25 at 03:20 PM, during an interview with Licensed Practical Nurse (LPN) #1, she explained the Certified Nurse Aides (CNAs) are to notify them if a resident does not have a BM for three (3) consecutive days and the electronic health record (EHR) will trigger an alert for anyone with 3 days of no BM. She reported that the facility has standing physician's orders for medications to give if needed for residents with no BM. She confirmed that the physician is not always notified of no bowel movements unless the medications are not effective. On 04/08/25 at 04:00 PM, during an interview with the Director of Nursing (DON), she confirmed Resident#25 was hospitalized with a	M 500	* 100% audit of "Facility Alert Listing Report" on bowl movements was completed by Director of Nursing on 04/11/25. All concerns were addressed by Registered Nurse with no adverse findings. Physician was notified there were no concerns identified. In-service was given by Director of Nursing on 04/10/25 regarding notification of Physician for any changes including all Activity of Daily Living Changes. * 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. Director of Nursing and/or Registered Nurse will check alerts including Bowel movements daily beginning 04/11/25 and will bring report to stand-up meeting with clinical team each morning. Registered Nurse and/or Licensed Practical Nurse will follow up with Certified Nurse Aide and resident about alert including Bowl Movement. Registered nurse and/or Licensed Practical Nurse will follow standing orders and care plan to resolve alert. At the end of each shift, the Registered Nurse will check to make sure the alert is completed. Director of Nursing is to follow up every 72 hours for eight weeks beginning 04/11/25 and ending	

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M 500	Continued From page 5 fecal impaction several months ago. She explained the resident had a history of diarrhea and constipation and when she experienced diarrhea, medications were administered to stop it. The CNAs are to notify the nurse if there are no BMs in 3 consecutive days and then the nurse is to give the resident medications and notify the physician if there are no changes. She confirmed she was not aware the resident was not having BMs, and explained the physician did see the resident prior to the hospital admission in January. On 04/09/2025 at 10:45 AM, during a follow up interview with the DON, she acknowledged there was no documentation of nursing interventions, constipation medications administered, or provider notification regarding the gaps in bowel movements prior to the hospitalization for Resident #25. On 04/10/25 at 12:45 PM, during a phone interview with Resident #25's Physician, he explained he is familiar with the resident and explained the resident has had irritable bowels, with alternating patterns of diarrhea and constipation. He confirmed Resident #25 was on Lomotil for diarrhea and reported he was aware the resident was admitted to the hospital several months ago for a fecal impaction. However, he was not informed that the resident had no BMs or documentation of no BM for 6 consecutive days prior to being sent to the hospital. The facility has standing orders to follow if a resident has no BM. He confirmed that if he had been notified that Resident #25 had no BMs for consecutive days, he would have implemented orders for constipation. A record review of Resident #25's "Admission	M 500	06/06/25.	

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M 500	Continued From page 6	M 500		

Record" revealed the facility originally admitted the resident on 03/01/2022 and she had a diagnosis of Constipation. Diagnoses added with an onset date of 2/5/2025 included Hemorrhage Of Anus And Rectum and Fecal Impaction.

A record review of Resident #25's "Quarterly Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 04/03/25 revealed a Brief Interview for Mental Status (BIMS) score of 13, which indicated she was cognitively intact. Resident dependent on staff for toileting hygiene and frequently incontinent of bowel and bladder.

A record review of the facility's "Documentation Survey Report" for January 2025 revealed Resident #1 experienced multiple days without a documented bowel movement. Specifically, there was no documented bowel movement on January 1, 2, 3, and 5, and again on January 14, 15, 16, 17, 18, and 19, which was six (6) consecutive days. There was also no bowel movement documented on January 23, 24, and 28.

A record review of the medical record revealed there was no documentation of nursing interventions, assessments, or physician notification to address Resident #25's ongoing constipation or lack of consecutive days with no BM during the month of January 2025.

A record review of an acute hospital "Summary of Care Document" confirmed that Resident #1 was hospitalized from 01/30/2025 through 02/04/2025 with multiple medical issues, including a diagnosed fecal impaction.

A record review of the Resident's Medication Administration Record (MAR) for January 2025 revealed Resident #25 continued to receive

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M 500	Continued From page 7 Lomotil (antidiarrheal medication) three (3) times daily despite the documented days of no BM. Additionally, no medications were administered for constipation, including Miralax (type of laxative medication) that was ordered to be administered PRN (as needed).	M 500		
M 620	45.21.4 Urinary incontinence Urinary incontinence. Residents with urinary incontinence shall be assessed for need of bladder retraining program. An indwelling catheter will not be used unless the resident ' s clinical condition indicates that catheterization is necessary. These residents shall receive treatment and services to prevent urinary tract infections. This Statute is not met as evidenced by: Level II Based on observation, interview, record review, and facility policy review, the facility failed to ensure appropriate incontinence care was provided, as evidenced by the failure to cleanse the skin during a brief change for one (1) of two (2) residents observed for incontinence care (Resident #13). Findings included: A review of the facility's policy titled, "Perineal Care," revised 8/25/2014, revealed, "...Procedure ...5. Clean perineal area well with soap and warm water taking care to clean from front to back using a clean washcloth or clean area of the cloth for each stroke. 6. Rinse perineal area, moving from front to back using a clean area of the washcloth or towelette or use another clean	M 620	*The Certified Nurse Aide was educated 04/08/25 by the Director of Nursing on Proper perineal Care. * All residents have the potential to be affected by this practice. *The Director of Nursing provided education to all Certified Nursing Assistants beginning on 04/10/25 and ending on 05/06/25. Skills checks will be preformed on all Certified Nursing Assistants by 05/06/25. *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,	5/5/25

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M 620	Continued From page 8 washcloth or towelette for each stroke. (Note: Not all products require rinsing. Follow product instructions). 7. Dry perineal area moving from front to back. Use a blotting motion with towel. 8. Turn resident on side. 9. Clean, rinse (as applicable) and dry buttocks and perianal area without contaminating perineal area. 10. Remove wet incontinent pad or protective linen. Change gloves and perform hand hygiene ..." On 4/8/25 at 2:20 PM, during an observation of incontinence care, and interview with Certified Nurse Aide (CNA) #1, she explained that Resident #13 was dependent on staff for activities of daily living (ADLs) and was incontinent of bowel and bladder. Resident #13 was lying in bed, and his brief was soiled with urine. Disposable wipes were noted on the bedside table. CNA #1 removed the soiled brief and applied a clean one without cleansing or rinsing the perineal area or buttocks. The CNA repositioned the resident and covered him with a blanket. On 4/8/25 at 2:50 PM, during a follow-up interview with CNA #1, she confirmed she changed Resident #13's soiled brief and did not provide perineal care. She stated she was nervous during the observation and forgot, but she knew the appropriate procedure. She acknowledged that failing to cleanse the resident could contribute to urinary tract infections and skin breakdown. On 4/9/25 at 4:00 PM, during an interview with the Director of Nursing (DON), she stated her expectation is for staff to always provide proper incontinence care to prevent infections or skin breakdown.	M 620	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. Audits of perineal care will be completed by Director of Nursing and/or Registered Nurse beginning 04/10/25. This audit will include two Certified Nursing Assistants preforming hands on demonstration of perineal care two times weekly beginning 04/10/25 for four weeks and will be validated by the Director of Nursing and/or Registered Nurse. Perineal audit forms will be reviewed with the Administrator and Director of Nursing weekly times four weeks, then monthly times three months. Any deficient practice will be brought to the Quality Assurance Performance Improvement Committee for correction action plan.	

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M 620	Continued From page 9 A record review of the "Admission Record" revealed the facility admitted Resident #13 on 3/10/25 with diagnoses including Metabolic Encephalopathy. A record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/16/25 revealed Resident #13 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated his cognition was severely impaired. Further review revealed he was frequently incontinent of bowel and bladder and dependent on staff for toileting hygiene.	M 620		
M 815	45.29.1 Safe Food Handling Procedures Safe Food Handling Procedures. Food shall be prepared, held, and served according to current Mississippi State Department of Health Food Code Regulations. This Statute is not met as evidenced by: Level II Widespread Based on observation, staff interviews, record review, and facility policy review, the facility failed to maintain a sanitary and pest-free environment in the kitchen by not ensuring effective pest control measures were implemented and sustained for two (2) of three (3) kitchen observations. Findings included: A review of the facility's policy, "Sanitization" (undated), revealed, " ...The food service area shall be maintained in a clean and sanitary manner. Policy Interpretation and Implementation 1. All kitchens, kitchen areas shall be... protected	M 815	*Food service area was cleaned completely on 04/11/25 by Dietary staff and Dietary Manager. All bagged goods and cereal were sealed in plastic containers and shelves were wiped down before placing containers back on shelves. All food carts were cleaned and sanitized to be ready for next meal service. * All residents can be affected by this practice. * Dietary staff was in-serviced 04/10/25 by Dietary Manager on their cleaning schedules and responsibilities to assure	5/5/25

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M 815	Continued From page 10 from rodents, roaches, flies, and other insects." A review of the facility's "Pest Control Policy," dated 4/10/23, revealed, " ...Our facility shall maintain an effective pest control program. Policy Interpretation and Implementation 1. This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents ...6. Maintenance services assist, when appropriate and necessary, in providing pest control services." On 4/7/25 at 10:02 AM, during the initial kitchen tour with the Dietary Manager, the dry goods storage area was observed. A cardboard box containing individually packaged cereal had small, black, rice-sized objects and shredded cardboard inside. The Dietary Manager confirmed the rice-sized objects appeared to be rat droppings. A glue trap with what appeared to be peanut butter smeared on top was observed on the floor of the pantry area. The Dietary Manager stated he was unaware of when the kitchen was last treated for rodents. He reported concern that rodents may be entering through a small gap beneath the kitchen's back door, which leads directly outside. On 4/9/25 at 8:50 AM, during a phone interview with the Registered Dietitian (RD), she explained she performs monthly kitchen tours at the end of each month. She stated she had not observed pest or rodent activity during those walk throughs. She stated her expectations were for dietary staff to maintain an effective pest control plan and adhere to sanitation standards. On 4/9/25 at 10:00 AM, during an interview with the Maintenance Supervisor, he stated he was unaware of rodent activity in the kitchen but	M 815	kitchen is clean and sanitary for preparation of meal service. Pest Control was directed on 04/18/25 by Administrator to come weekly for four weeks, then bi-weekly for three months, then monthly unless there were any signs of pest or rodents seen. * 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. Rounds will be made twice weekly for four weeks, then weekly for four weeks then monthly for 3 months beginning 04/10/25 and ending 09/05/25 by Dietary Manager and/or Administrator to check for cleanliness of the Kitchen.	

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M 815	Continued From page 11	M 815		

acknowledged that rodents may have entered through a gap under the back door. He explained the rear kitchen area had a two-door system-a screen door and a solid, sealed door. He reported that staff had previously left the solid door open to allow air circulation when the air conditioning system was not functioning. He stated the air system was scheduled to be repaired that day.

On 4/9/25 at 11:04 AM, during an observation of the assembly line plating, a live roach was observed crawling across a resident's meal tray. The tray was immediately removed after confirmation by the Dietary Manager, Dietary Aide, Head Cook, and Maintenance Supervisor.

On 4/10/25 at 9:10 AM, during observation of the low-temperature dishwasher, a live roach was observed crawling on top of the machine.

On 4/10/25 at 1:10 PM, during an interview with the Administrator, she was informed of the pest-related concerns identified during two (2) of three (3) kitchen inspections. She stated she had been unaware of pest issues in the kitchen and acknowledged that high staff turnover had affected kitchen oversight. She emphasized that her expectations were for food to be prepared safely, the kitchen to be maintained in a clean and organized condition, and for pest infestations to be minimized.

A record review of the facility's pest control logs revealed treatments for rodents and pests had occurred since December 2024.

A review of the facility's pest control logs revealed the pest control company were targeting mice and roaches with roaches and rodent activity noted on visits during the monthly visits for the

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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) COMPLETE DATE
M 815	Continued From page 12 months of January, February, and March 2025.	M 815		