STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255095	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE CENTER OF LAUREL	935 WEST DR , LAUREL, Mississippi, 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
F0000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 8/4/25 through 8/7/25. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and F569, F584, F641, F656, and F812. The facility had a census of 88 and was licensed for 105 beds.	F0000		
F0569 SS = D	Notice and Conveyance of Personal Funds CFR(s): 483.10(f)(10)(iv)(v) §483.10(f)(10)(iv) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits- (A) When the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and (B) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. §483.10(f)(10)(v) Conveyance upon discharge, eviction, or death. Upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with State law. This REQUIREMENT is NOT MET as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to ensure that a resident had trust account funds refunded to their	F0569		

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0569 SS = D	Continued from page 1 family within 30 days after death for one (1) of three (3) closed records reviewed. (Resident #91) Findings Include: A review of the facility's "General Resident Trust Fund Policies", dated 04/25, revealed, "…Conveyance Upon Discharge or Death Upon discharge or in the event of death of a resident with personal funds deposited with the facility, the facility must refund within 30 days the funds and a final accounting of those funds to the resident. In the event of death funds must be refunded to the Estate of or sent to the State Unclaimed Property Division if no heir can be identified within 30 days…" A record review of the "Admission Record" revealed the facility admitted Resident #91 on 9/27/2023 with diagnoses including Amyotrophic Lateral Sclerosis (ALS). A record review of the Discharge Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/6/2025 revealed Resident #91was coded for "Death in facility". A record review of the "Progress Notes" revealed a "Nursing Note", dated 5/6/25 at 9:31 (AM) indicated Resident #91 expired at the facility. A record review of the "Resident Statement" revealed Resident #91 had a balance of $2.00 that remained in the account at the time of his death. The account was documented as closed on 5/19/2025. A record review of a facility-issued check written to the resident's family indicated the check was dated 8/7/2025, which was more than 90 days after the resident's death. On 8/7/2025 at 10:38 AM, during an interview with the Nursing Home Administrator (NHA), he stated he recently started the process of refunding families after the death of residents because he was new to the facility. He further stated that he was unaware of the requirement to return trust fund balances within 30 days of a resident's death.	F0569		
F0584 SS = D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable	F0584		

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F0584 SS = D	Continued from page 2 and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interview, and facility policy review, the facility failed to ensure a homelike and comfortable environment by failing to address a persistent, unpleasant noise caused by a malfunctioning resident room door for three (3) of four (4) days of the survey.	F0584		

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F0584 SS = D	Continued from page 3 Findings include: Record review of the facility policy titled "Resident Environment", dated 9/15/25 revealed, “It is the policy of this facility to provide a safe, clean, comfortable and homelike environment…” During observations from 8/4/25 through 8/6/25, multiple times throughout the day, there was a high-pitched, squealing noise heard from the hallway. The noise was very loud and could be heard through the closed door in the training room. The noise occurred multiple times throughout the day of survey and was notably loud and unpleasant. On 8/6/25 at 1:45 PM, during an observation of Percutaneous Endoscopic Gastrostomy (peg) tube care, the wound care nurse closed Resident #53's door to provide privacy during the care. When she closed the door, the metal door rubbed the floor and caused the unpleasant, high-pitched noise that had been heard throughout the survey. On 8/6/25 at 2:32 PM, during interviews with Certified Nurse Aides (CNAs) #1 and #2, both staff were asked to open the door to Room #53 and acknowledged hearing the loud squealing noise caused by the metal door rubbing the floor. The CNAs stated the issue had been ongoing for a while and that they typically left the door open because the residents were nonverbal and the door was only closed during care. They both agreed the sound was unpleasant and could affect residents but admitted they had not reported the issue to maintenance because "no one ever complained." On 8/6/25 at 2:35 PM, during an interview with Licensed Practical Nurse (LPN) #1, she stated the loud noise from the door had been occurring for several months. She explained she had not submitted a maintenance request because no residents had complained, but agreed the sound was unpleasant and could be disturbing to the residents who are unable to voice their concerns. On 8/6/25 at 2:45 PM, during an interview and observation with the Maintenance Director, the door to Room #53 was closed and it made a loud noise. He stated that typically nurses or CNAs will either submit a work order or notify him verbally of an issue with equipment. He reported that nothing had been brought to	F0584		

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F0584 SS = D	Continued from page 4 his attention regarding the loud, squeaking door. He determined that the problem could be resolved by removing the current kick plate and replacing it. On 8/7/25 at 11:44 AM, in an interview with the Director of Nursing (DON), she stated that any staff who become aware of a problem with functioning equipment should notify the Maintenance Supervisor by submitting a work order. She confirmed that all staff interviewed had been aware of the problem for several months. She stated it is her expectation that staff notify maintenance of such issues so they can be addressed in a timely manner. The DON added that while the resident affected by this problem could not verbally communicate to complain, the noise could have been an irritating stimulus or disrupted the resident's sleep pattern, as the resident is aware of her surroundings but unable to express concerns.	F0584		
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material	F0641		

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F0641 SS = D	Continued from page 5 and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the resident's active diagnoses of Atrial Fibrillation (Resident #4) and failed to ensure the completion of an entry and discharge MDS (Resident #90) for two (2) of 19 sampled residents. Findings included: A review of the facility's policy "MDS Process", revised 12/20, revealed, "...The RAI (Resident Assessment Instrument) is the source document to be used for further MDS coding guidelines, time schedules and requirements..." The RAI User's Manual, Chapter 1 requires the assessment accurately reflects the resident's status and Chapter 2 indicates that an Entry Tracking Record must be completed at the time of admission, and a Discharge Tracking Record or Discharge MDS must be completed when the resident is discharged. Resident #4 A record review of the "Admission Record" revealed the facility admitted Resident #4 on 6/3/24 with diagnoses including Type 2 Diabetes Mellitus. A record review of the "Patient Discharge Instructions" for Resident #4, dated 4/4/25 revealed, "…New Medications… apixaban (type of anticoagulant medications) … Impression and Plan Diagnosis: New onset A-fib (Atrial fibrillation) with RVR (Rapid Ventricular Rate)" A record review of the Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/20/25 revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated she was cognitively intact. Section I – Active Diagnoses did not include Atrial Fibrillation as an active diagnosis, despite documentation in the medical record. On 8/5/25 at 3:51 PM, in an interview with the Director	F0641		

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F0641 SS = D	Continued from page 6 of Nursing (DON), she stated she is currently performing quality assurance (QA) duties and oversees the MDS and care plan nurses. The DON confirmed that Resident #4 returned from the hospital on 4/4/25 with a new diagnosis of A-fib with RVR (Rapid Ventricular Rate) and the Annual MDS failed to reflect the diagnosis. She stated she expected the MDS to be accurate and updated daily when new orders are received and reviewed quarterly with the comprehensive assessment. She stated the nurse must have missed the new diagnosis since it was not added to the resident's current diagnoses in the electronic health record (EHR). Resident # 90 A record review of the 'Admission Record' revealed the facility admitted Resident #90 on 4/4/24 with diagnoses including Cerebral Infarction. A record review of a "Nursing Note" revealed Resident #90 returned from the hospital on 7/16/25. A record review of a "Transfer Out Note" revealed Resident #90 was sent out for evaluation on 7/31/25. A record review of the electronic health record (EHR) for Resident #90 indicated the last activity occurred on the Minimum Data Set (MDS) was a "Discharge Return Anticipated" assessment, dated 7/2/25. There was no entry MDS noted for the return on 7/16/25, nor was a discharge assessment noted for the 7/31/25 discharge to the hospital. On 8/6/25 at 4:25 PM, during an interview with the DON, she stated the MDS assessments with appropriate ARDs should have been completed in a timely manner. She explained the facility was currently recruiting a QA nurse for the MDS/Care Plan department.	F0641		
F0656 SS = E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan	F0656		

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F0656 SS = E	Continued from page 7 must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to develop a comprehensive care plan for four (4) of 19 sampled residents. (Resident #3, Resident #4, Resident #17, and Resident #31) Findings included: A review of the facility's policy, "Care Plan Process", revised 12/24, revealed, "...Regulations require	F0656		

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F0656 SS = E	Continued from page 8 facilities to complete...a comprehensive, standardized assessment of each resident's functional capacity and needs...The results of the assessment...are to be used to develop...each resident's comprehensive person-centered plan of care...The Care Plan must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being..." Resident #3 A record review of the "Admission Record" revealed the facility admitted Resident #3 on 1/3/24 with diagnoses including Chronic Obstructive Pulmonary Disease and Encounter for Prophylactic Measures. A record review of the "Order Review History Report" revealed Resident #3 had a Physician's Order, dated 1/3/24 for Apixaban 5 milligrams (mg) two times a day for Atrial Fibrillation (A-fib). A record review of the Comprehensive Care Plan revealed there was no care plan developed to include interventions related to anticoagulant therapy. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/28/25 revealed Resident #3 had Brief Interview for Mental Status (BIMS) score of 15, which indicated he was cognitively intact. Further review revealed he had taken anticoagulant medication during the lookback period. Resident #4 A record review of the “Admission Record” revealed the facility admitted Resident #4 on 6/3/24 with diagnoses including Type 2 Diabetes Mellitus. A record review of the “Patient Discharge Instructions” dated 4/4/25 revealed, “…New Medications… apixaban (type of anticoagulant medications) … Impression and Plan Diagnosis: New onset A-fib (Atrial fibrillation) with RVR (Rapid Ventricular Rate) …” A record review of the "Order Review History Report" revealed Resident #4 had a Physician's Order dated 4/4/25 for Apixaban 5 mg two times a day for A-Fib. A record review of the Comprehensive Care Plan revealed there was no care plan developed to include interventions for the diagnosis of Atrial fibrillation, or the risks related to anticoagulant therapy.	F0656		

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F0656 SS = E	Continued from page 9 A record review of the Annual MDS with an ARD of 5/20/25 revealed Resident #4 had a BIMS score of 15, which indicated she was cognitively intact. During an interview on 8/5/25 at 3:51 PM, the Director of Nursing (DON), she stated she is currently performing Quality Assurance (QA) duties and oversees the MDS and care plan nurses. The DON confirmed that Resident #4 returned from the hospital on 4/4/25 with a new diagnosis of A-fib with RVR (Rapid Ventricular Rate). She acknowledged that there was no care plan for the anticoagulant or the diagnosis of A-fib. She stated she expected care plans to be developed daily when new orders or information is received and reviewed quarterly with the comprehensive assessment. She stated the nurse must have missed the new diagnosis since it was not added to the electronic health record (EHR). In a follow up interview on 8/6/25 at 11:00 AM, the DON confirmed that a care plan had not been developed for anticoagulant therapy for Resident #3 and explained the facility had been without a QA nurse for several months which had contributed to the failure to develop the care plans. Resident #17 On 8/4/25 at 3:14 PM, during an interview, Resident #17 reported that she was dependent upon staff to assist with changing her. A record review of the “Admission Record” revealed the facility admitted Resident #17 on 6/13/25 and she had current diagnoses including Morbid (Severe) Obesity. A record review of the Quarterly MDS with an ARD of 5/15/25 revealed Resident #17 had a BIMS score of 15, which indicated she was cognitively intact. A review of Section GG revealed Resident #17 was dependent on staff for toileting hygiene. A record review of Resident 17's medical record revealed there was no care plan developed that included bowel and bladder care. On 8/7/25 at 10:05 AM, during an interview, the DON stated she was aware that care plans had not been developed and that the facility was in the process of hiring an MDS nurse. Resident #31 A record review of the “Admission Record” revealed the	F0656		

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F0656 SS = E	Continued from page 10 facility admitted Resident #31 on 7/22/21 with diagnoses including Obstructive Uropathy. A record review of the “Order Review History Report” revealed Resident #31 had a Physician’s Order, dated 7/5/24, to change the catheter and catheter bag monthly and as needed. A record review of the Quarterly MDS with an ARD of 6/18/25, revealed Resident #31 had a BIMS score of 15 and had an indwelling catheter. A record review of Resident #31’s medical record revealed there was no care plan developed to address the indwelling urinary catheter. On 8/6/25 at 11:52 AM, during an interview with the DON, she confirmed the care plan did not address the indwelling catheter or any related interventions. She stated the care plan should have been developed to include this information and explained that the facility previously employed a case manager who was responsible for updating care plans, but that person was terminated in January. She added that she and other staff had been trying to correct care plans since that time.	F0656		
F0812 SS = E	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	F0812		

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F0812 SS = E	Continued from page 11 food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to store, label, and date food items in a sanitary manner and ensure tray line temperatures were consistently documented, for one (1) of two (2) kitchen observations. Findings included: A review of the facility's policy titled "Storage of Canned and Dry Food" with a revision date of 9/23 revealed, "…Procedure…8. Opened packages are stored in tightly covered containers or Ziploc bags…" A review of the facility's policy titled "Resident Tray Service and Delivery" with a revision of 05/18 revealed, "…Procedure…g. The temperatures of food is taken with a calibrated thermometer and documented on the Temperature Monitoring Log…" On 8/4/25 at 10:32 AM, during an observation of the kitchen with the Dietary Manager (DM), in the dry storage room, there was a partially torn pack of hamburger buns with two missing, an opened pack of coffee filters, American cheese wrapped in saran wrap with a hole exposing slices to air, an open 25-pound box of instant thickener, and a brown box of croissant rolls with one pack torn open. In the freezer, several plastic bags were torn open, including a 10-pound box of pork sausage links, a 10-pound box of turkey sausage links, a 10-pound box of sausage patties, a 15-pound box of fried egg patties, and a 20-pound box of chocolate chip dough. In the refrigerator, a clear plastic container of sliced lemons was observed with visible mold, a gallon container of grape Kool-Aid with lemons had no label or date, and a nearly empty gallon container of ranch dressing had no open date. A record review of the "Daily Food Temperature Monitoring Log" revealed missing documentation for dinner temperatures on 7/5, 7/18, 7/19, 7/20, and 7/25. It also revealed missing documentation for lunch on 7/22. On 8/4/25 at 11:08 AM, during an interview with the DM, she stated that all open food items should be sealed or placed in plastic bags to prevent contamination. She explained that unsealed food could cause residents to become sick. She stated it was her responsibility to	F0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255095	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE CENTER OF LAUREL	935 WEST DR , LAUREL, Mississippi, 39440

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F0812 SS = E	Continued from page 12 ensure staff followed proper procedures. She also explained that the final cooking temperatures should be recorded for each meal to confirm that food is cooked and served at appropriate temperatures and to reduce the risk of foodborne illness. On 8/6/25 at 10:57 AM, during an interview with the cook, she stated she always checks tray line temperatures but sometimes forgets to write them down.	F0812		