STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255262	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURELWOOD COMMUNITY LIVING CENTER	**1036 WEST DRIVE , 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 two (2) Complaint Investigations (CI MS #2667820 and CI MS #2693055), at the facility from 12/15/25 through 12/16/25. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid. CI MS #2667820 was investigated related to a fall and F689 was cited. CI MS #2693055 was investigated regarding resident neglect and there were no citations regarding the complaint. The facility held a license for 60 beds, with a census of 43.	F0000		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on interviews and record review, the facility failed to ensure adequate supervision and take appropriate actions to prevent an avoidable accident when staff continued transporting a resident after the resident removed his seatbelt and staff failed to stop the transport and request assistance, resulting in the resident falling from his wheelchair inside the facility van, for one (1) of five (5) sampled residents, Resident #1. Findings include: A record review of the “Admission Record” revealed the	F0689		

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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F0689 SS = D	Continued from page 1 facility admitted Resident #1 on 2/4/2025 with diagnoses including Encephalopathy. A record review of the Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/9/25 revealed Resident #1 had a Brief Interview for Mental Status Summary score of 8, which indicated his cognition was moderately impaired. A record review of the facility's fall report, dated 10/13/25 at 11:45 AM, revealed Resident #1 had an "incident Location" of "Facility Vehicle" with a "Predisposing Situation Factors" including "During Transfer." On 12/15/2025 at 9:27 AM, during an interview with the Complainant, she reported that two (2) months ago, Resident #1 was dropped from his seat while on the van following a doctor's appointment On 12/15/2025 at 11:23 AM, during an interview with Resident #5 who was also on the facility van on 10/13/25, stated that Resident #1 was upset because he wanted to go home with his sister who had been at the doctor's appointment with him. Resident #1 was cursing CNA #1 and was repeatedly taking his seat belt off. CNA #1 had to stop and refasten the seat belt. On 12/15/2025 at 11:30 AM, during an interview with the Certified Nurse Aide (CNA) #1, he revealed he was the driver of the facility's van on 10/13/2025 when Resident #1 fell from wheelchair. CNA #1 reported that on 10/13/25, he was driving Resident's #1 and another resident from a doctor's appointment at a local clinic. The Driver affirmed that he followed protocol and bolted the chair wheels in place and put the seat belt on the passengers. The Driver reported that Resident #1 kept saying he wanted to go home with his sister, who had joined him at his appointment. The Driver stated that Resident #1unfastened his seatbelt and he would pull over and refasten the belt and encourage Resident #1 to stay fastened in his seat for his safety. The Driver affirmed that the resident took his seatbelt off a second time and fell to the floor of the van. The Driver reported that he pulled the van over, assessed the resident, talked to him and got him back in his chair. The Driver acknowledged that he and his passengers were within 2 miles of the facility, so he continued to drive and when he reached the facility the nurse was waiting and he reported the incident. On 12/15/2025 at 1:50 PM, an interview with the Director of Nursing (DON) revealed she acknowledged the resident's fall on the van on 10/13/2025. The DON	F0689		

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F0689 SS = D	Continued from page 2 stated the Driver told her that the resident unfastened his belt twice, falling on the second time. The DON stated the resident was assessed by the RN supervisor upon his return to the facility and was found to have an abrasion over his left eye. The DON noted that the resident was sent to the hospital as a standard precaution and was returned the same day. The DON affirmed that the resident's behavior problem of repeatedly unfastening his belt was at the root of the incident. The DON further acknowledged that the saftest action for the driver to take at the initial unfastening of the seatbelt would have been to pull over, notify the facility to be directed on which way to go. The DON stated she and another nurse or CNA would have met the van to provide assistance. The DON stated that it was reported to her that the van was less within 2-3 miles of the facility. The DON stated she expects residents to be transported safely. On 12/15/2025 at 2:15 PM, an interview with the Administrator revealed she felt the Driver did not do anything wrong by refastening the Resident #1's seatbelt. The Administrator acknowledged that Resident #1 was displaying behavior problems by removing his seatbelt and his behavior problem was the root cause of the incident	F0689		