Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(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
M0000	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 Minimum Standards for Institutions for the Aged or Infirm, state licensure requirement. CI MS #2667820 was investigated related to a fall and M640 was cited. CI MS #2693055 was investigated regarding resident neglect and there were no citations regarding the complaint.	M0000		
M0640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This LICENSURE 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 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.	M0640		

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

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M0640	Continued from page 1 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 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	M0640		

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M0640	Continued from page 2 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	M0640		