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 03/25/2026

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 a Complaint Investigation (CI MS #2805886), at the facility on 3/25/26. CI MS #2805886 was a facility reported incident (FRI) investigated for misappropriation. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F602 and F761. The facility held a license for 60 beds, with a census of 54 residents.	F0000		
F0602 SS = D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and facility policy review, the facility failed to prevent the misappropriation of resident property when staff left a controlled substance unattended, resulting in (30) Hydrocodone/Acetaminophen 10-325 milligram tablets prescribed for Resident #1 being unaccounted for and lost for one (1) of four (4) residents reviewed for abuse. (Resident #1). Findings include: A review of the facility's "Abuse and Neglect Policy and Procedure" (undated) revealed, "…Policy: To provide a safe environment for all residents free of abuse…II. Types of Abuse…7. Misappropriation of Resident Property means 'the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's	F0602		

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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F0602 SS = D	Continued from page 1 belongings or money without the resident's consent'. Examples…Missing prescription medications or diversion of a resident medications, including…limited to controlled substances..." A review of the facility's "Medication-Controlled Substances Policy and Procedure" (undated) revealed "…Procedure: 1…Only authorized licensed nursing and pharmacy personnel have access to controlled medications. 2. All controlled substances, CII-V are stored and maintained in a locked cabinet or compartment…4. Accurate accountability of the inventory of all controlled drugs is always maintained…" A record review of the facility's investigation dated 03/18/26 revealed on 03/13/26 at approximately 9:40 PM, a pharmacy courier delivered thirty (30) Hydrocodone/Acetaminophen 10-325 milligram tablets for Resident #1 to the facility with a packing slip and narcotic accountability record, which were received and signed for by Licensed Practical Nurse (LPN) #2. The investigation revealed the medication was not signed onto the narcotic accountability record and could not be located. A record review of the "Admission Record" revealed the facility admitted Resident #1 on 03/03/26 with diagnoses including Fracture of Left Femur. A record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/09/26 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of (15), which indicated the resident was cognitively intact. A record review of the "Order Summary Report" revealed a physician's order dated 03/03/26 for Hydrocodone-Acetaminophen 10-325 milligram tablets. A record review of the "Employee Corrective Coaching Form" dated 03/14/26 for LPN #1 and LPN #2 revealed both staff received a written warning for leaving medications, including controlled substances, unattended at the nurses' station. A record review of the "Packing Slip Proof of Delivery" revealed Hydrocodone-Acetaminophen 10-325 milligram tablets for Resident #1 were delivered on 03/13/26 at 9:47 PM and electronically signed as received by LPN #2. A record review of the "Drug Record Book" revealed Hydrocodone-Acetaminophen 10-325 milligram tablets were ordered on 03/12/26 and documented as received on	F0602		

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F0602 SS = D	Continued from page 2 03/13/26. A record review of the “Controlled Drugs-Count Record” for March 2026 revealed Licensed Practical Nurse (LPN) #1 signed responsibility for the medication cart and controlled substances for the 7:00 AM to 3:00 PM shift on 03/13/26 and relinquished responsibility at the beginning of the 11:00 PM to 7:00 AM shift on 03/13/26. A record review of the “Package Count” for the South Hall narcotic box from 02/05/26 through 03/24/26 revealed no documentation of receipt of Hydrocodone/Acetaminophen 10-325 milligram tablets for Resident #1. On 03/25/26 at 12:29 PM, during an interview with Licensed Practical Nurse (LPN) #1, she reported receiving the blister pack of (30) Hydrocodone/Acetaminophen 10-325 milligram tablets for Resident #1 from LPN #2 and placing the medication on the nurses’ station while she left the area. LPN #1 reported the medication was left unattended and later could not be located. She acknowledged the medication should have been secured immediately. On 03/25/26 at 3:07 PM, during an interview with Licensed Practical Nurse (LPN) #2, she reported signing for the delivery of the Hydrocodone/Acetaminophen 10-325 milligram tablets for Resident #1 and transferring the medication to LPN #1. She reported both nurses were in the medication room while the medication remained unattended at the nurses’ station. On 03/25/26 at 4:30 PM, during an interview with the Director of Nursing (DON), she reported being notified on 03/14/26 at approximately 7:00 AM that the medication was missing. The DON reported an investigation was initiated and confirmed the medication could not be located. She reported the investigation revealed the medication had been left unattended at the nurses’ station. On 03/25/26 at 4:45 PM, during an interview with the Administrator, she reported staff failed to ensure controlled medications were secured and accessible only to authorized personnel. The Administrator confirmed the facility was unable to determine the location of the missing medication. On 03/25/26 at 5:00 PM, during an interview with Resident #1, the resident reported being informed the Hydrocodone/Acetaminophen tablets delivered on 03/13/26 had been lost and was replaced by the facility.	F0602		
F0761 SS = D	Label/Store Drugs and Biologicals	F0761		

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F0761 SS = D	Continued from page 3 CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure medications were stored and handled in accordance with accepted professional standards when staff failed to immediately secure controlled medications upon receipt for Resident #1 and failed to store medications according to manufacturer's instructions for Resident #3, for two (2) of four (4) sampled residents. Findings include: A review of the facility policy, "Medications Storage Policy and Procedure" (undated), revealed, "Medications and biologicals will be maintained in a secured locations only accessible to designated staff…3. Schedule II controlled medications will be maintained within a separately locked permanently affixed compartment. Record of receipt and disposition of controlled medications will be maintained". Resident #1	F0761		

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F0761 SS = D	Continued from page 4 A record review of the “Admission Record” revealed the facility admitted Resident #1 on 03/03/26 with diagnoses including Fracture of Left Femur. A record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/09/26 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of (15), which indicated the resident was cognitively intact. A record review of the “Order Summary Report” revealed a physician’s order dated 03/03/26 for Hydrocodone-Acetaminophen 10-325 milligram tablets. A record review of the facility investigation dated 3/18/26 revealed on 3/13/26 at approximately 9:40 PM pharmacy courier delivered (30) Hydrocodone/Acetaminophen 10/325 milligram tablets for Resident #1, which were received and signed for by Licensed Practical Nurse (LPN) #2; however, the medications were not documented as secured in the narcotic count system and were later unable to be located. During an interview on 3/25/26 at 12:29 PM, LPN #1 explained she received Resident #1’s Hydrocodone/Acetaminophen from LPN #2 and left the medication unattended at the nurses’ station while she went to complete other tasks instead of immediately securing it in the locked medication cart. During an interview on 3/25/26 at 3:07 PM, LPN #2 explained he received Resident #1’s-controlled medication from the pharmacy courier and provided it to LPN #1 and confirmed the medication had not been immediately secured in the locked medication cart following delivery. Resident #3 A record review of the “Admission Record” revealed the facility admitted Resident #3 on 3/23/26 with diagnoses including heart disease. A record review of the BIMS Interview dated 3/23/26 revealed Resident 3 had a BIMS score of (10), which indicated his cognition was moderately impaired. A record review of the “Order Summary Report” revealed Resident #3 had a Physician’s Order, dated 3/23/26, for Lorazepam (Ativan) oral concentrate. A record review of the “Individual Patient’s Narcotics	F0761		

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F0761 SS = D	Continued from page 5 Record" for Resident #3 revealed two (2) containers of Lorazepam were signed into the narcotic record on 3/23/26. A record review of the "Lorazepam Oral Concentrate: Package Inert/Prescribing Info (Information), reviewed 2/5/26, revealed, "…How is Lorazepam Oral Concentrate supplied…PROTECT FROM LIGHT Store at Cold Temperature-Refrigerate…36 (degrees)-46 (degrees) F (Fahrenheit)…" On 3/25/26 at 3:00 PM, during an observation, LPN #3 and LPN #2 completed a controlled drug count on South Hall. Two (2) bottles of Lorazepam Oral 2 milligrams per milliliter (2 mg/ml) for Resident #3 were observed stored in the locked medication cart despite manufacturer labeling indicating, "Store at Cold Temperature-Refrigerate 36-46 degrees F". On 3/25/26 at 3:00 PM, during an interview, LPN #3 confirmed the manufacturer's instructions on the Lorazepam label but stated she was unsure why the medication had not been refrigerated. On 3/25/26 at 3:07 PM, during an interview, LPN #2 explained he was aware the Lorazepam for Resident #3 required refrigeration and acknowledged it had been stored in the medication cart instead of the designated medication refrigerator. On 3/25/26 at 4:30 PM, during an interview, the Director of Nursing (DON) explained the expectation was for nursing staff to immediately secure controlled medications in the locked medication cart upon receipt and document the medications to maintain accountability and prevent unauthorized access. She confirmed the facility had a locked refrigerator located in the medication room for medications requiring refrigeration and expected staff to follow manufacturer storage instructions.	F0761		