STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255262	A. BUILDING _____ B. WING _____	05/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURELWOOD COMM 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) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual survey at the facility from 05/28/19 to 05/30/19. During the survey, the SA determined the facility was not in compliance with the requirements of participation for Medicare and Medicaid. The SA cited regulatory deficiencies at F641, F656, F842, and F868. The census at the time of the survey entrance was 48, and the facility was certified for 60 beds..	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on facility policy review, record review, and staff interview, the facility failed to accurately code the comprehensive Minimum Data Set (MDS) assessment for one (1) of 15 resident MDSs reviewed for Resident #51. Findings include: A review of facility's policy titled, "Resident Assessment using the MDS", with no revision date, revealed "every resident will be assessed using the MDS according to the guidelines set forth in the Resident Assessment Instrument (RAI) manual. Each person completing a section of the MDS attests to its accuracy by affixing his/her signature to that section. Record review of Resident #51's MDS for Discharge Status revealed the resident was	F 641	1. Resident #51 was affected by the deficient practice. The Minimum Data Set (MDS) Registered Nurse (RN) Coordinator corrected Resident #51's Comprehensive MDS discharge assessment code on 6/3/2019 to show the resident was discharged home. 2. The MDS RN Coordinator did a 100% audit on all residents discharged in the past 30 days from 5/15/2019 through 6/15/2019. All discharged MDS assessments were coded correctly. 3. The MDS RN Coordinator and MDS Licensed Practical Nurse(LPN) Coordinator was educated on 6/15/2019 by Regional Consultant on double checking the coding for all residents discharged from the facility are correct. 4. The Director of Nursing (DON) will	7/19/19

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

Electronically Signed | 06/20/2019

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F 641	Continued From page 1 discharged from facility, on 04/27/19, to an acute care hospital. Record review of Resident #51's Clinical Planned Discharge Summary-V4, revealed Resident #51's recent admission was 03/05/19, and discharge was 04/27/19 to an acute care hospital. A Record review of Resident #51's Progress Notes dated 04/27/19 at 9:56 AM, revealed Resident #51 was discharged home with her son at her side via private vehicle. An interview, on 05/29/19 at 4:20 PM, with the Interim Director of Nurses (DON)/MDS Coordinator revealed, "I must have miscoded the Minimum Data Set (MDS)". The Interim DON revealed, "The resident did discharge home with her son". The Interim DON pulled the MDS up on her computer and verified Resident #51's MDS was miscoded showing she went to an acute hospital, but she actually discharged home with her son. An interview, on 05/30/19 at 10:55 AM, with Licensed Practical Nurse (LPN) #2 revealed, "Resident #51 discharged home from the facility with her son".	F 641	coordinate the daily Interdisciplinary Clinical Meeting to review previous day's discharges and to ensure the MDS assessments was coded correctly. The DON will monitor five (5) times a week for one (1) week starting on 6/17/2019 through 6/23/2019 and then audit weekly x three (3)weeks starting 6/24/2019 through 7/19/2019 to ensure that residents discharged from the facility MDS assessment is coded correctly. All negative findings will be correctly weekly by the MDS Coordinator and the DON will report monthly to the Quality Assurance Committee for review, revision or resolution of plan.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §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	F 656		7/19/19

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F 656	Continued From page 2 medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan 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. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, record review and facility policy review, the facility failed to develop a Plan of Care for Resident #45's behaviors, for one (1) of fifteen resident care	F 656	1. Resident #45 was affected by the deficient practice. The Minimum Data Set (MDS) Registered Nurse (RN) Coordinator corrected Resident #45's	

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F 656	Continued From page 3 plans reviewed. Findings include: Review of the facility's policy titled, "Care Plans-Comprehensive", dated June 1, 2000, revealed it is facility's policy to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and psychological needs. This policy also indicated the care plan was to be designed to incorporate identified problem areas. Review of Resident #45's Comprehensive Care Plan revealed no Focus, Goals, or Interventions to address her false accusation behavior, which required two staff members present at all times to provide her daily care. In an interview with Resident #45, on 05/28/19 3:25 PM, she stated staff "bite" her arm, a "few days ago". Slight bruising was noted to the left forearm, but no defined bite marks. Resident #45 was unable to say who, give a description or shift it occurred. In a few minutes, Resident #45 stated that someone grabbed her left arm, and did not indicate her arm was bitten by staff. Resident #45 then stated she didn't want anything done about it. In an interview, on 05/28/19 3:48 PM, with the facility's Administrator, she stated Resident #45 had a Basic Interview for Mental Status (BIMS) score of 8 or 9. The Administrator stated the resident would play one (1) son against the other in an attempt to go home, but it was not safe for the resident to go home alone.	F 656	comprehensive care plan to include a plan of care to address behaviors on 05/29/2019. 2. The Social Service (SS) Coordinator did a 100% audit on all residents who had behaviors in the past 30 days from 5/15/2019 through 6/15/2019. There were 5 residents identified with behaviors and all identified residents had a care plan in place for behaviors. 3. The MDS RN Coordinator, MDS Licensed Practical Nurse(LPN) Coordinator, LPNs, SS Coordinator, and RNs was educated on 6/6/2019 by the Administrator on developing a care plan for behaviors. 4. The Director of Nursing (DON) will coordinate the daily Interdisciplinary Clinical Meeting to review the previous day's report of residents' behaviors and to ensure care plans have been updated to reflect reported behaviors. The DON will monitor five (5) times a week for one (1) week starting on 6/17/2019 through 6/23/2019 and then audit weekly x three (3)weeks starting 6/24/2019 through 7/19/2019 to ensure that residents with behaviors have a care plan in place for behaviors. All negative findings will be corrected weekly by the SS Coordinator and the DON will report monthly to the Quality Assurance Committee for review, revision or resolution of plan.	

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F 656	Continued From page 4 In an interview with Licensed Practical Nurse (LPN) #1, on 5/28/19 4:30 PM, she stated Resident #45 makes up stories, and there has to be two (2) staff members at a time to provide care for her because she will tell lies on the staff. LPN #1 stated she was not sure if this was care planned or not. When asked if someone makes up stuff to require two (2) staff members be present when providing care, should this be a part of their care plan? She responded, "Yes". In an interview with the facility's Administrator, on 05/29/19 at 4:30 PM, she stated that the allegation of staff biting Resident #45 was reported to the State Agency and the Attorney General's office, and an investigation was being conducted. Review of the Admission Record revealed Resident #45 was admitted by the facility, on 09/7/18, with the included diagnoses of Cognitive Communication Deficit, Repeated Falls, High Blood Pressure, Disorientation, and Pressure Ulcers to the right and left buttock. Review of Resident #45's Admission Minimum Data Set (MDS), with the Assessment date of 04/16/19, reviewed Resident #45 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated she was cognitively intact.	F 656		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in	F 842		7/19/19

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F 842	Continued From page 5 accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.	F 842		

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F 842	Continued From page 6 §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review and facility policy review, the facility failed to accurately document Resident #45's skin condition on the weekly skin audits for one (1) of two (2) residents reviewed for Pressure Ulcer concerns, for a total of 15 records reviewed. Findings include: On 05/30/19 at 1:56 PM, an observation of Resident #45's Pressure Ulcer care to the Left Lateral Foot and Right Buttock, provided by Registered Nurse (RN) #1 and assisted by LPN #3, revealed the Stage 2 wound was almost healed. No concerns with care was identified, and no infection control concerns were identified.	F 842	1. Resident #45 was affected by the deficient practice. The Minimum Data Set (MDS) Registered Nurse (RN) Coordinator corrected Resident #45's skin audit on 5/28/2019. 2. The MDS RN Coordinator did a 100% audit on all residents with wound/skin issues who had body audits in the past 30 days from 5/15/2019 through 6/15/2019. All residents body audits were correct. 3. The MDS RN Coordinator, MDS Licensed Practical Nurse(LPN) Coordinator, LPNs and RNs were educated on 6/15/2019 by Unit Manager RN on the correct way to document the identification of skin concerns when a body audit is performed.	

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F 842	Continued From page 7 Review of Resident #45's Weekly Pressure Injury Records, from 04/09/19 to 05/16/19, revealed the presence of the Stage 2 Pressure Ulcer to the left gluteal. The Weekly Pressure Injury Records from 04/09/19 thru 05/22/19 revealed the presence of the Unstagable Wound to the right heel. The Weekly Pressure Injury Record from 04/09/19 thru 05/22/19 revealed the presence of the Stage 3 Pressure Ulcer to the right gluteal. The Weekly Non-Pressure Wound Report from 04/09/19 to 05/23/19 revealed the presence of the left lateral foot wound due to trauma from the resident's shoe. Review of Resident #45's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/16/19, revealed one Stage 2 and one Stage 3 pressure ulcers which were present on admission, and one Unstagable wound. Review of Resident #45's Care Plan revealed the Focus for a Stage 3 Pressure Ulcer (PU) to the right gluteal, an Unstagable Pressure Ulcer to the right heel, and a Non-Pressure/Hypergranulation wound to the left lateral foot related to trauma from shoe. All concerns were initiated on 04/11/19. On 05/29/19 at 4:00 PM, an interview with Licensed Practical Nurse (LPN) #1 revealed she stated when she does body audits weekly, "If nothing is new or different I just put skin intact". LPN #1 stated even if they are known to have skin concerns, she would document on the audits no concerns. LPN #1 stated, "If I need to do it different just let me know". Review of Resident #45's Weekly Body Audits	F 842	4. The Director of Nursing (DON) will coordinate the daily Interdisciplinary Clinical Meeting to review previous day body audits on residents with wound/skin issues to ensure the RN/LPN documented the correct way to identify any skin concerns on the body audit that was performed. The DON will monitor five (5) times a week for one (1) week starting on 6/17/2019 through 6/23/2019 and then audit weekly x three (3)weeks starting 6/24/2019 through 7/19/2019 to ensure that residents discharged from the facility MDS assessment is coded correctly. All negative findings will be correctly weekly by the MDS Coordinator and the DON will report monthly to the Quality Assurance Committee for review, revision or resolution of plan.	

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F 842	Continued From page 8 dated 05/07/19, 05/22/19, and 05/28/19, revealed LPN #1 had documented #1 "Skin Intact". Review of the Weekly Body Audits, dated 04/16/19, 04/23/19, 04/30/19, and 05/14/19, documented by RN #1 or LPN #4 revealed #2 "No new skin alterations" was checked. Record review of Resident #45's Admission Record revealed she was admitted by the facility with a Stage 2 PU to the left buttock, a Stage 3 PU to the right buttock, and a Non-Pressure Chronic Ulcer of the Right Heel and Midfoot with unspecified severity, on 04/09/19. On 05/29/19 at 4:00 PM, an interview with Licensed Practical Nurse (LPN) #1 revealed she stated when she does body audits weekly, "If nothing is new or different I just put skin intact". LPN #1 stated even if they are known to have skin concerns, she would document on the audits no concerns. LPN #1 stated, "If I need to do it different just let me know". On 05/29/19 at 3:20 PM, during an interview the Interim Director of Nurses (DON) stated the Charge Nurse was responsible for measuring the wounds, and update the skin assessments. The Interim DON stated it was not correct to put "skin intact" on a body audit if the resident has skin concerns, and confirmed the medical record was inaccurate.	F 842		
F 868 SS=B	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of:	F 868		7/19/19

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F 868	Continued From page 9 (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced by: Based on facility policy review, record review, and staff interview, the facility failed to conduct the required Quarterly Quality Assessment and Assurance (QAA) meetings for two (2) of the four (4) quarters in 2018 that were reviewed, the 3rd and 4th Quarters. Findings include: Review of an untitled typed document on the facility's letterhead, provided, signed, and dated 05/30/19, by the facility's Administrator,revealed the Quality Assurance and Performance Improvement (QAPI) plan reviews, and the Quality Assessment and Assurance (QAA) are one in the same at the facility. The facility document also stated the facility follows the QAPI process for Quality Assessment(s) and Assurance(s). Review of the facility's policy titled, "Quality Assessment and Performance Improvement", dated April 10, 2013, revealed the policy of this facility is the facility will implement and maintain a	F 868	1. No Residents were affected by the deficient practice. 2. The Administrator did a 100% audit on all Quality Assurance (QA) Meetings from 5/15/2019 through 6/15/2019. The QA meeting held on 5/16/2019 had a signature sheet with the signature of all attendees. A QA meeting was held on 6/20/2019 with signature sheet in place. 3. The Director of Nursing, Minimum Data Set (MDS) Registered Nurse (RN) Coordinator, Social Service (SS), Medical Records, Life Connection Coordinator, Dietary Manager, Business Office, Therapy Director, RN Supervisors and MDS Licensed Practical Nurse(LPN) Coordinator were educated on 6/15/2019 by the Administrator on the importance of having monthly QA meetings with the Interdisciplinary Team, quarterly with the Medical Director and keeping documentation from meeting including the signature page. During the QA meeting on 6/20/2019 the Medical Director was	

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F 868	Continued From page 10 Quality Assurance and Performance Improvement (QAPI) program. The facility policy also stated the QAPI committee will consist of the facility Administrator, the Director of Nursing (DON), the Medical Director, and at least three (3) other designated key staff members. The facility policy stated the committee will meet no less than monthly, and the Medical Director will attend the QAPI meetings no less than quarterly. Review of the facility's QAA attendance rosters for each quarter of 2018, and the first quarter of 2019, revealed the facility did not have a signed attendance roster for the 3rd or 4th quarter of 2018. During an interview, on 05/30/2019 at 2:02 PM, with the Administrator, it was confirmed she was unable to locate the signed QAA attendance roster for the 3rd and 4th Quarterly QAA meetings. The Administrator stated she had not been the acting Administrator at the time those meeting were held.	F 868	educated on the importance of the meeting, participating quarterly in the meeting and keeping records. 4. The Director of Nursing (DON) will coordinate the daily Interdisciplinary Clinical Meeting to review documentation needed to conduct QA meeting. The DON will monitor monthly starting 6/17/2019 to ensure all QA minutes and signatures are recorded from QA meeting. All report findings will be corrected monthly and reported monthly to the Quality Assurance Committee for review, revision or resolution of plan. The QA Committee will meet monthly with Interdisciplinary Team and Quarterly with the Medical Director to ensure issues are being identified and addressed as needed for this facility.	

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	255262	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/31/2019**

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(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
K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000		

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

Electronically Signed | 06/20/2019

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 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255262	A. BUILDING _____ B. WING _____	05/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURELWOOD COMM 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) COMPLETION DATE
E 000	Initial Comments * EMERGENCY PREPAREDNESS * Survey conducted on 5/31/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were identified.	E 000		

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

Electronically Signed | 06/20/2019

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