

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34HH	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/06/2022
NAME OF PROVIDER OR SUPPLIER CARE CENTER OF LAUREL		STREET ADDRESS, CITY, STATE, ZIP CODE 935 WEST DR 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) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted an annual survey and four (4) complaint investigations (CI) from 1/3/22 to 1/6/22. The SA substantiated CI MS #17957 related to incontinent care. CI MS# 18036 related to Activities of Daily Living (ADL) care and abuse, CI MS #17654 related to verbal abuse, CI MS #18184 related to ADL care, medications not given and personal property missing was not substantiated. During the survey the SA determined that the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements at M and cited M 620 and M 640.	M 000		

Mississippi State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

01/28/22