| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 255095 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **01/06/2022** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CARE CENTER OF LAUREL** | **935 WEST DR**<br>**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 |
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| K 000 | INITIAL COMMENTS<br><br>42 CFR 483.70(a)<br><br>This facility was surveyed under the Centers for Medicare Medicaid Services (CMS) COVID-19 Emergency Declaration Blanket 1135 Waivers for Health Care Provider. The facility must meet the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA) ... | K 000 | | |
| K 355 SS=D | Portable Fire Extinguishers<br>CFR(s): NFPA 101<br><br>Portable Fire Extinguishers<br>Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers.<br>18.3.5.12, 19.3.5.12, NFPA 10<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, the facility failed to select, installed, inspected, and maintained in portable fire extinguishers in accordance with NFPA 101 section 19.3.5.12 and NFPA 10, Standard for Portable Fire Extinguishers. The deficient practice affected the entire facility on the day of the survey.<br><br>Findings Include:<br><br>On 1/6/22 at 11:15AM, observation revealed four (4) of eight (8) fire extinguishers in the facility were overdue for 6-year inspection and were | K 355 | By submitting the enclosed materials, we are not admitting to the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceeding and submit these responses pursuant to our regulatory obligations.<br><br>On 1/6/2022 Administrator placed a call to Seal Safety Services, LLC regarding expired fire extinguishers. Safety Seal Representative came to the facility and replaced 4 fire extinguishers on 1/6/2022 and came to replace 3 fire extinguishers on 1/11/2022.<br><br>79 out of 82 Residents have the potential | 1/28/22 |

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

Electronically Signed | 01/28/2022

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| K 355 | Continued From page 1<br>outdated/missing inspection collars. The four (4) fire extinguishers were located near Room 2, Room 43, Room 60, and MDS Office of the facility<br><br>The findings were acknowledged by the Administrator and Maintenance Supervisor verified this observation during the exit interview on 1/6/22. | K 355 | to be affected by this deficient practice<br><br>on 1/7/2022 Administrator in serviced the Maintenance Director on the Fire Extinguisher Requirements Policy. On 1/6/2022 the facility held a Quality Assurance Meeting with no changes noted to current policies.<br><br>On 1/6/2022 Administrator began monitoring all fire extinguishers to ensure that they are all up to date. Monitoring will continue to occur once a week for 4 weeks and then once a month for 3 months. The Quality Assurance Committee will evaluate audits/documentation completed monthly for 3 months and make recommendations and changes to ensure accuracy | |
| K 521 SS=D | HVAC<br>CFR(s): NFPA 101<br><br>HVAC<br>Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications.<br>18.5.2.1, 19.5.2.1, 9.2<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, the facility failed to provide heating, ventilation, and air conditioning in accordance with NFPA 101 sections 19.5.2.1, 9.2 and NFPA 90A section 4.3.12.1. This | K 521 | By submitting the enclosed materials, we are not admitting to the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or | 2/14/22 |

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| K 521 | Continued From page 2<br>standard deficiency can affect the entire facility and residents on the day of survey.<br><br>On 1/6/22 at 10:15 AM, observation revealed the main egress corridors/hallways were being used as supply, air, and exhaust plenum for the HVAC system in the facility. The main egress corridors were incapable of limited passage of smoke throughout the facility.<br><br>It was also observed the HVAC was installed in the facility around 1969 and the continuing waiver (CMS S&C-06-18) for this deficiency expired on 9/25/2020.<br><br>The finding was acknowledged by the Administrator and verified by the Maintenance Supervisor during the exit interview. | K 521 | allegations as part of any proceeding and submit these responses pursuant to our regulatory obligations.<br><br>On 1/24/2022 the Administrator placed a call to the Mississippi State Department of Health regarding deficient practice. Contact was made on 1/25/2022 with instructions on application of continuing waiver for current HVAC System.<br><br>79 out of 82 Residents have the potential to be affected by this deficient practice<br><br>On 1/7/2022 the Administrator in serviced the maintenance director on HVAC System in regards to having a waiver in place that is applicable for 3 years. On 1/31/2022 the Administrator submitted the request for the continuing waiver in accordance to S&C-06-18. On 1/6/2022 the facility held a Quality Assurance Meeting with no changes noted to current policies.<br><br>On 1/25/2022 the Administrator spoke with representative from the Mississippi State Department of Health with instructions on application for waiver that will support current HVAC System. On 1/31/22 the Administrator submitted the request for the continuing waiver in accordance to S&C-06-18. The Administrator will check waiver dates annually to ensure that it is up to date. The Quality Assurance Committee will evaluate audits/documentation completed monthly for 3 months and make recommendations and changes to ensure | |

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| K 521 | Continued From page 3 | K 521 | compliance. | |