STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255095	A. BUILDING _____ B. WING _____	C 01/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE CENTER OF LAUREL	**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) COMPLETION DATE
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey along with a complaint investigation (CI MS #16759, CI MS #16851, CI MS #17239) was conducted by the State Agency (SA) on 1/7/2021. The facility was found to be in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. At the time of the survey, the facility had a census of 82 and held a license for 120 beds. CI MS #16759 The result of the investigation was unsubstantiated with no deficiencies cited for Verbal Abuse. The SA determined the facility was in compliance with Medicare and Medicaid requirements for participation. CI MS #16851 The result of the investigation was unsubstantiated with no deficiencies cited for Dietary Services related to Food is Cold, and Resident Food Precautions Not Honored, Missappropriation of Property related to Resident Personal Items, Quality of Care related to Resident Not Groomed Adequately, Physical Environment related to Safe Environment Not Provided, Infection Control, and Unqualifed Personnel related to Staff Improperly Qualified. The SA determined the facility was in compliance with Medicare and Medicaid requirements for participation. CI MS #17239 The result of the investigation was	F 000		

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

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.

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F 000	Continued From page 1 unsubstantiated with no deficiencies cited for Dietary Services related to Food Not Palatable and Insufficient Food, Quality of Care related to Facility Staffing, No Weight Loss Assessment, Resident Not Groomed Adequately, and Physical Environment related to Facility Not Clean. The SA determined the facility was in compliance with Medicare and Medicaid requirements for participation.	F 000		