STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34NH	A. BUILDING: _____ B. WING _____	C 08/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURELWOOD COMMUNITY 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) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted a Complaint Investigation (CI), MS #19489 and MS #19490, at the facility from 8/29/22 to 8/30/22. During the survey, the SA determined the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements. The SA substantiated the complaints for misappropriation of a resident's money and M500 was cited.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to	M 500		9/30/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34NH	A. BUILDING: _____ B. WING _____	C 08/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURELWOOD COMMUNITY 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) COMPLETE DATE
M 500	Continued From page 1 participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34NH	A. BUILDING: _____ B. WING _____	C 08/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURELWOOD COMMUNITY 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) COMPLETE DATE
M 500	Continued From page 2	M 500		

responsibility to the facility for any period of time in conformance with State law;

7. is free from mental and physical abuse;
8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint;
9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract;

10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;

11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;

12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34NH	A. BUILDING: _____ B. WING _____	C 08/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURELWOOD COMMUNITY 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) COMPLETE DATE
M 500	Continued From page 3 documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to protect a resident from misappropriation of property for one (1) of four (4) sampled residents. Resident #1 Findings Include:	M 500	* Resident #1 was assessed 08/05/22 by Registered Nurse, (RN) with no adverse findings. All Items purchased were accounted for by Resident #1 and Administrator 08/05/22. All money left over from purchases was returned 08/05/22 but twenty ($20) dollars. Twenty	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34NH	A. BUILDING: _____ B. WING _____	C 08/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURELWOOD COMMUNITY 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) COMPLETE DATE
M 500	Continued From page 4 Review of the facility's policy, "Freedom from Abuse, Neglect and/or Exploitation Prevention Plan Education," dated 11/14/17 revealed, "The resident has the right to be free from ... misappropriation of residents property ..." ` Record review of the facility's investigation dated 8/5/22 and signed by the Administrator, revealed Resident #1 notified her nurse that she had asked Certified Nursing Assistant (CNA) #1 to take her Electronic Benefit Transfer (EBT) card and some cash to go shopping for her. She stated she paid CNA #1 $140 in cash and gave her EBT card to buy snacks for her and her roommate and to get her four (4) T-shirts/camisoles, two (2) bralettes, hairspray, shampoo and a grooming kit. CNA #1 had brought her all the items except the T-shirts and bralettes because she had left them in her truck. She did not work the next couple of days and did not have a phone so Resident #1 canceled her card not knowing what had happened. An interview with CNA #1 stated she did bring all items, change and receipts. CNA #1 was suspended pending investigation. In the investigation it was determined that although the resident has a BIMS of 15, she did receive the rest of her items, which were four (4) T-shirts and two (2) bralettes. Resident #1 told CNA #1 to use her card for food for her family, which she did. CNA #1 was terminated for not following facility policy. The money was replaced. Record review of a statement dated 7/30/22 and signed by the Administrator revealed, " ...(Proper Name of Resident #1) said she shouldn't have asked (Proper Name of CNA #1) to shop for her and she didn't want to get her in any trouble. I (Administrator) asked (Proper Name of Resident #1) if she told (Proper Name of CNA #1) she could shop for herself with the EBT card and she	M 500	($20) dollars was replaced by facility on 08/12/22. * All residents have the potential to be effected. * All alert residents were interviewed by Social Services 08/05/22 and completed 08/10/22 to determine any other concerns with Misappropriation of Resident Property. In-service education was completed by Administrator regarding Abuse, Neglect, Misappropriation of property, and Resident Rights on 07/30/22 with all employees. Resident Council invited Administrator and Social Services 08/09/22 in to educate residents on shopping procedures to assure prevention of any possibility of Misappropriation of Resident Property. Only the Activity Director or Business office Manager are allowed to make purchases for the residents. * Three residents will be interviewed weekly for three weeks by Administrator regarding Misappropriation of Property beginning 09/01/22. Administrator interviewed residents in resident council 08/09/22. Activity Director will interview residents on 09/29/22for two months to assure no further complaints of Misappropriation are present. Any concerns will be brought to facilities Quality Assessment and Performance Improvement meeting on 09/29/22 and for next two monthly meetings for corrective action.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34NH	A. BUILDING: _____ B. WING _____	C 08/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURELWOOD COMMUNITY 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) COMPLETE DATE
M 500	Continued From page 5	M 500		

said yes. It was not discussed how much she allowed (Proper Name of CNA #1) to use but (Proper Name of Resident #1) told me she figured maybe between $50.00-$75.00."

Record review of the facility's "Witness Interview Statement" dated 7/30/22 and signed by Licensed Practical Nurse (LPN) #1 revealed, "(Proper Name of Resident #1) informed this nurse that the transportation employee (Proper Name of CNA #1) had gotten resident ebt card and 140$ in cash. Resident stated that (Proper Name of CNA #1) told her she did not have money for gas or food to eat. Resident stated (Proper Name of CNA #1) asked to use the ebt card to buy grocers so she can eat and use $40.00 of the cash for gas. Resident stated about $150 was used by (CNA #1) on the EBT card and that (Proper Name of CNA #1) only used $30 of the cash on (Proper Name of Resident #1). (Proper Name of Resident #1) stated that (Proper Name of CNA #1) has gave her the run around and that there are text messages about the situation as well."

Record review of the facility's "Witness Interview Statement" dated 7/30/22 and signed by Registered Nurse (RN) #1 revealed, "Resident stated to this nurse and (Proper Name of LPN #1) that a staff member (Proper Name of CNA #1) spent money on her EBT card and took cash from her that she did not get back. Resident showed me and (Proper Name of LPN #1) text messages on her phone ...DON notified and aware."

Record review of a handwritten statement (undated) and signed by CNA #1 revealed, " ... (Proper Name of Resident #1 asked me to get her money off a treasury card. She also asked me to take her EBT card and get her and her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34NH	A. BUILDING: _____ B. WING _____	C 08/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURELWOOD COMMUNITY 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) COMPLETE DATE
M 500	Continued From page 6	M 500		

roommate some snacks. I got her money and food and brought everything back to her cash, food & 2 cards. When I come to work the following day she said when she called her ebt card that I left too much money on it and I should get myself some snacks for work. She gave me a list of things she wanted, non food items & gave me $140.00 in cash. I bought every-thing on her list and gave her back her ebt card and $40. The only thing I didn't give her was 4 shirts & 2 bras which was lost in my car. Those 4 shirts & 2 bras and $20 have been given to her. The $20.00 for the headache I caused for her worrying. I got everything she asked for and returned it. I did not intend on the delay to get her stuff back. Things happened out of my control and I was without a vehicle for several days ..."

During an interview with Resident #1 on 8/29/22 at 10:40 AM, she stated that during the time the event happened in July of this year (2022), the Activities person was out sick. Activities staff would usually pick up items at the store for her as needed. CNA #1 offered to pick up what Resident #1 needed from the store. Resident #1 asked CNA #1 to pick up some snacks, T-shirts, bralettes, shampoo and hair spray. Resident #1 said that she gave CNA #1 her "Treasury Card" to get $140 cash and her Electronic Benefit Transfer (EBT) card. Resident #1 stated that she told CNA #1 that she could use $50 from the EBT card to get food for her (CNA #1) and her (CNA #1) family. Resident #1 explained that she was trying to help the CNA out because she was having a hard time and she felt sorry for her. Resident #1 became concerned when CNA #1 did not return to work for three (3) days. She called to check on any transactions related to her EBT card and was informed that an additional $70 had been spent from the card. At that time, Resident #1 canceled

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34NH	A. BUILDING: _____ B. WING _____	C 08/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURELWOOD COMMUNITY 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) COMPLETE DATE
M 500	Continued From page 7	M 500		

her Treasury Card and EBT card. She then notified the staff that CNA #1 only brought back some of the items she had requested. The Administrator made CNA #1 bring the remaining items and $20 of the cash. The facility also gave Resident #1 $20 in cash. Resident #1 said she only got $40 dollars back and she "didn't want to get her in trouble, but I am out $70 dollars that I did not authorize her to use on my EBT card". Resident #1 commented that she "really felt sorry for her and I don't want to get her in trouble". Resident #1 pulled up text messages from her phone between her and CNA #1 from Sunday, 7/24/22 at 2:28 PM, CNA #1 texted Resident #1 "Hey Mrs. (Proper Name of Resident #1) ...I would have brought you the stuff Friday but I literally had no gas. And had a flat tire. I have your ebt card and I only spent 100.00 of your money ...there's 40 ...do you mind if I use it for gas." Resident #1 did not respond to the text. The next text was Monday, 7/25/22 at 9:25 AM, "Mrs. (Proper Name of Resident #1) I will see you around 6 this evening. I have stuff for you to bring. Also I am having issues with the bosses there at (Proper Name of Facility). So if you don't mind. Don't let them know we have spoke. I hope things can be worked out but I will see you this afternoon."

An interview with LPN #1, on 8/29/22 at 1:47 PM, revealed that Resident #1 had told her that the CNA told the resident she was broke and did not have money for food or gas. The resident told me she gave the CNA her treasure card to get cash and her EBT card. She told the CNA she could use $50 off the EBT card to buy groceries for her family. The CNA still had the resident's stuff, and the resident said the CNA used about $110 to $120 off her EBT card.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34NH	A. BUILDING: _____ B. WING _____	C 08/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURELWOOD COMMUNITY 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) COMPLETE DATE
M 500	Continued From page 8 On 8/29/22 at 1:57 PM, in an interview with Registered Nurse (RN) #1, she stated that LPN #1 asked her to witness Resident #1's statement. RN #1 confirmed her written statement that the resident stated CNA #1 spent money on her EBT card and took cash from her and did not repay her. Resident #1 then showed LPN #1 and RN #1 the text message exchange between her and CNA #1 that she kept on her phone. The Director of Nurse (DON) was then notified. During an interview with the Administrator on 8/30/22 at 1:46 PM, she stated Resident #1 gave the staff (CNA #1) permission to use the EBT card and gave her the password. The resident told the staff to buy her family groceries. The Administrator verified that she had read the text messages exchanged between Resident #1 and CNA #1 in which CNA #1 was asking to use the resident's money for gas. The Administrator stated she did not see anything that would indicate the staff (CNA #1) had manipulated the resident. Record review of the "Admission Record" revealed that Resident # 1 was admitted by the facility on 6/16/22, with diagnoses including include Metabolic Encephalopathy, Adjustment Disorder with Mixed Anxiety and Depressed Mood, and Anxiety Disorder. Record review of the Admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 6/24/22 revealed Resident #1 had a Brief Interview of Mental Status (BIMS) score of 15, indicated the resident was cognitively intact. Record review of the "Freedom from Abuse, Neglect and/or Exploitation Prevention Plan Education" and the "Vulnerable Adults' Prevention	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34NH	A. BUILDING: _____ B. WING _____	C 08/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURELWOOD COMMUNITY 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) COMPLETE DATE
M 500	Continued From page 9 Policy" revealed, CNA #1 signed the document on 3/10/22, which indicated she received training related to abuse, including misappropriation of personal property and vulnerable adults.	M 500		