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	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care Center of Laurel	935 West Dr Laurel, MS 39440

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and facility policy review, the facility failed to ensure that a resident had trust account funds refunded to their family within 30 days after death for one (1) of three (3) closed records reviewed. (Resident #91)Findings Include:A review of the facility's General Resident Trust Fund Policies, dated 04/25, revealed, .Conveyance Upon Discharge or Death Upon discharge or in the event of death of a resident with personal funds deposited with the facility, the facility must refund within 30 days the funds and a final accounting of those funds to the resident. In the event of death funds must be refunded to the Estate of or sent to the State Unclaimed Property Division if no heir can be identified within 30 days.A record review of the admission Record revealed the facility admitted Resident #91 on [DATE] with diagnoses including Amyotrophic Lateral Sclerosis (ALS).A record review of the Discharge Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] revealed Resident #91was coded for Death in facility.A record review of the Progress Notes revealed a Nursing Note, dated [DATE] at 9:31 (AM) indicated Resident #91 expired at the facility.A record review of the Resident Statement revealed Resident #91 had a balance of $2.00 that remained in the account at the time of his death. The account was documented as closed on [DATE].A record review of a facility-issued check written to the resident's family indicated the check was dated [DATE], which was more than 90 days after the resident's death.On [DATE] at 10:38 AM, during an interview with the Nursing Home Administrator (NHA), he stated he recently started the process of refunding families after the death of residents because he was new to the facility. He further stated that he was unaware of the requirement to return trust fund balances within 30 days of a resident's death.

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and facility policy review, the facility failed to ensure a homelike and comfortable environment by failing to address a persistent, unpleasant noise caused by a malfunctioning resident room door for three (3) of four (4) days of the survey. Findings include: Record review of the facility policy titled Resident Environment, dated 9/15/25 revealed, It is the policy of this facility to provide a safe, clean, comfortable and homelike environment.During observations from 8/4/25 through 8/6/25, multiple times throughout the day, there was a high-pitched, squealing noise heard from the hallway. The noise was very loud and could be heard through the closed door in the training room. The noise occurred multiple times throughout the day of survey and was notably loud and unpleasant. On 8/6/25 at 1:45 PM, during an observation of Percutaneous Endoscopic Gastrostomy (peg) tube care, the wound care nurse closed Resident #53's door to provide privacy during the care. When she closed the door, the metal door rubbed the floor and caused the unpleasant, high-pitched noise that had been heard throughout the survey. On 8/6/25 at 2:32 PM, during interviews with Certified Nurse Aides (CNAs) #1 and #2, both staff were asked to open the door to room [ROOM NUMBER] and acknowledged hearing the loud squealing noise caused by the metal door rubbing the floor. The CNAs stated the issue had been ongoing for a while and that they typically left the door open because the residents were nonverbal and the door was only closed during care. They both agreed the sound was unpleasant and could affect residents but admitted they had not reported the issue to maintenance because no one ever complained. On 8/6/25 at 2:35 PM, during an interview with Licensed Practical Nurse (LPN) #1, she stated the loud noise from the door had been occurring for several months. She explained she had not submitted a maintenance request because no residents had complained, but agreed the sound was unpleasant and could be disturbing to the residents who are unable to voice their concerns. On 8/6/25 at 2:45 PM, during an interview and observation with the Maintenance Director, the door to room [ROOM NUMBER] was closed and it made a loud noise. He stated that typically nurses or CNAs will either submit a work order or notify him verbally of an issue with equipment. He reported that nothing had been brought to his attention regarding the loud, squeaking door. He determined that the problem could be resolved by removing the current kick plate and replacing it.On 8/7/25 at 11:44 AM, in an interview with the Director of Nursing (DON), she stated that any staff who become aware of a problem with functioning equipment should notify the Maintenance Supervisor by submitting a work order. She confirmed that all staff interviewed had been aware of the problem for several months. She stated it is her expectation that staff notify maintenance of such issues so they can be addressed in a timely manner. The DON added that while the resident affected by this problem could not verbally communicate to complain, the noise could have been an irritating stimulus or disrupted the resident's sleep pattern, as the resident is aware of her surroundings but unable to express concerns.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on record review, staff interview, and facility policy review, the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the resident's active diagnoses of Atrial Fibrillation (Resident #4) and failed to ensure the completion of an entry and discharge MDS (Resident #90) for two (2) of 19 sampled residents.Findings included: A review of the facility’s policy MDS Process, revised 12/20, revealed, .The RAI (Resident Assessment Instrument) is the source document to be used for further MDS coding guidelines, time schedules and requirements . The RAI User’s Manual, Chapter 1 requires the assessment accurately reflects the resident's status and Chapter 2 indicates that an Entry Tracking Record must be completed at the time of admission, and a Discharge Tracking Record or Discharge MDS must be completed when the resident is discharged . Resident #4 A record review of the “admission Record” revealed the facility admitted Resident #4 on 6/3/24 with diagnoses including Type 2 Diabetes Mellitus. A record review of the “Patient Discharge Instructions” for Resident #4, dated 4/4/25 revealed, “…New Medications… apixaban (type of anticoagulant medications) … Impression and Plan Diagnosis: New onset A-fib (Atrial fibrillation) with RVR (Rapid Ventricular Rate)” A record review of the Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/20/25 revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated she was cognitively intact. Section I – Active Diagnoses did not include Atrial Fibrillation as an active diagnosis, despite documentation in the medical record. On 8/5/25 at 3:51 PM, in an interview with the Director of Nursing (DON), she stated she is currently performing quality assurance (QA) duties and oversees the MDS and care plan nurses. The DON confirmed that Resident #4 returned from the hospital on 4/4/25 with a new diagnosis of A-fib with RVR (Rapid Ventricular Rate) and the Annual MDS failed to reflect the diagnosis. She stated she expected the MDS to be accurate and updated daily when new orders are received and reviewed quarterly with the comprehensive assessment. She stated the nurse must have missed the new diagnosis since it was not added to the resident’s current diagnoses in the electronic health record (EHR). Resident # 90 A record review of the 'admission Record' revealed the facility admitted Resident #90 on 4/4/24 with diagnoses including Cerebral Infarction. A record review of a “Nursing Note” revealed Resident #90 returned from the hospital on 7/16/25. A record review of a “Transfer Out Note” revealed Resident #90 was sent out for evaluation on 7/31/25. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of the electronic health record (EHR) for Resident #90 indicated the last activity occurred on the Minimum Data Set (MDS) was a “Discharge Return Anticipated” assessment, dated 7/2/25. There was no entry MDS noted for the return on 7/16/25, nor was a discharge assessment noted for the 7/31/25 discharge to the hospital. On 8/6/25 at 4:25 PM, during an interview with the DON, she stated the MDS assessments with appropriate ARDs should have been completed in a timely manner. She explained the facility was currently recruiting a QA nurse for the MDS/Care Plan department.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review, staff interview, and facility policy review, the facility failed to develop a comprehensive care plan for four (4) of 19 sampled residents. (Resident #3, Resident #4, Resident #17, and Resident #31)Findings included: A review of the facility’s policy, Care Plan Process, revised 12/24, revealed, .Regulations require facilities to complete .a comprehensive, standardized assessment of each resident's functional capacity and needs .The results of the assessment .are to be used to develop .each resident's comprehensive person-centered plan of care .The Care Plan must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . Resident #3 A record review of the admission Record revealed the facility admitted Resident #3 on 1/3/24 with diagnoses including Chronic Obstructive Pulmonary Disease and Encounter for Prophylactic Measures. A record review of the Order Review History Report revealed Resident #3 had a Physician's Order, dated 1/3/24 for Apixaban 5 milligrams (mg) two times a day for Atrial Fibrillation (A-fib). A record review of the Comprehensive Care Plan revealed there was no care plan developed to include interventions related to anticoagulant therapy. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/28/25 revealed Resident #3 had Brief Interview for Mental Status (BIMS) score of 15, which indicated he was cognitively intact. Further review revealed he had taken anticoagulant medication during the lookback period. Resident #4 A record review of the “admission Record” revealed the facility admitted Resident #4 on 6/3/24 with diagnoses including Type 2 Diabetes Mellitus. A record review of the “Patient Discharge Instructions” dated 4/4/25 revealed, “…New Medications… apixaban (type of anticoagulant medications) … Impression and Plan Diagnosis: New onset A-fib (Atrial fibrillation) with RVR (Rapid Ventricular Rate) …” A record review of the Order Review History Report revealed Resident #4 had a Physician's Order dated 4/4/25 for Apixaban 5 mg two times a day for A-Fib. A record review of the Comprehensive Care Plan revealed there was no care plan developed to include interventions for the diagnosis of Atrial fibrillation, or the risks related to anticoagulant therapy. A record review of the Annual MDS with an ARD of 5/20/25 revealed Resident #4 had a BIMS score of 15, which indicated she was cognitively intact. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/5/25 at 3:51 PM, the Director of Nursing (DON), she stated she is currently performing Quality Assurance (QA) duties and oversees the MDS and care plan nurses. The DON confirmed that Resident #4 returned from the hospital on 4/4/25 with a new diagnosis of A-fib with RVR (Rapid Ventricular Rate). She acknowledged that there was no care plan for the anticoagulant or the diagnosis of A-fib. She stated she expected care plans to be developed daily when new orders or information is received and reviewed quarterly with the comprehensive assessment. She stated the nurse must have missed the new diagnosis since it was not added to the electronic health record (EHR). In a follow up interview on 8/6/25 at 11:00 AM, the DON confirmed that a care plan had not been developed for anticoagulant therapy for Resident #3 and explained the facility had been without a QA nurse for several months which had contributed to the failure to develop the care plans. Resident #17 On 8/4/25 at 3:14 PM, during an interview, Resident #17 reported that she was dependent upon staff to assist with changing her. A record review of the “admission Record” revealed the facility admitted Resident #17 on 6/13/25 and she had current diagnoses including Morbid (Severe) Obesity. A record review of the Quarterly MDS with an ARD of 5/15/25 revealed Resident #17 had a BIMS score of 15, which indicated she was cognitively intact. A review of Section GG revealed Resident #17 was dependent on staff for toileting hygiene. A record review of Resident 17's medical record revealed there was no care plan developed that included bowel and bladder care. On 8/7/25 at 10:05 AM, during an interview, the DON stated she was aware that care plans had not been developed and that the facility was in the process of hiring an MDS nurse. Resident #31 A record review of the “admission Record” revealed the facility admitted Resident #31 on 7/22/21 with diagnoses including Obstructive Uropathy. A record review of the “Order Review History Report” revealed Resident #31 had a Physician’s Order, dated 7/5/24, to change the catheter and catheter bag monthly and as needed. A record review of the Quarterly MDS with an ARD of 6/18/25, revealed Resident #31 had a BIMS score of 15 and had an indwelling catheter. A record review of Resident #31’s medical record revealed there was no care plan developed to address the indwelling urinary catheter. On 8/6/25 at 11:52 AM, during an interview with the DON, she confirmed the care plan did not address the indwelling catheter or any related interventions. She stated the care plan should have been developed to include this information and explained that the facility previously employed a case manager who was responsible for updating care plans, but that person was terminated in January. She added that she and other staff had been trying to correct care plans since that time.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, record review, and facility policy review, the facility failed to store, label, and date food items in a sanitary manner and ensure tray line temperatures were consistently documented, for one (1) of two (2) kitchen observations. Findings included:A review of the facility's policy titled Storage of Canned and Dry Food with a revision date of 9/23 revealed, .Procedure.8. Opened packages are stored in tightly covered containers or Ziploc bags.A review of the facility's policy titled Resident Tray Service and Delivery with a revision of 05/18 revealed, .Procedure.g. The temperatures of food is taken with a calibrated thermometer and documented on the Temperature Monitoring Log.On 8/4/25 at 10:32 AM, during an observation of the kitchen with the Dietary Manager (DM), in the dry storage room, there was a partially torn pack of hamburger buns with two missing, an opened pack of coffee filters, American cheese wrapped in saran wrap with a hole exposing slices to air, an open 25-pound box of instant thickener, and a brown box of croissant rolls with one pack torn open. In the freezer, several plastic bags were torn open, including a 10-pound box of pork sausage links, a 10-pound box of turkey sausage links, a 10-pound box of sausage patties, a 15-pound box of fried egg patties, and a 20-pound box of chocolate chip dough. In the refrigerator, a clear plastic container of sliced lemons was observed with visible mold, a gallon container of grape Kool-Aid with lemons had no label or date, and a nearly empty gallon container of ranch dressing had no open date. A record review of the Daily Food Temperature Monitoring Log revealed missing documentation for dinner temperatures on 7/5, 7/18, 7/19, 7/20, and 7/25. It also revealed missing documentation for lunch on 7/22.On 8/4/25 at 11:08 AM, during an interview with the DM, she stated that all open food items should be sealed or placed in plastic bags to prevent contamination. She explained that unsealed food could cause residents to become sick. She stated it was her responsibility to ensure staff followed proper procedures. She also explained that the final cooking temperatures should be recorded for each meal to confirm that food is cooked and served at appropriate temperatures and to reduce the risk of foodborne illness.On 8/6/25 at 10:57 AM, during an interview with the cook, she stated she always checks tray line temperatures but sometimes forgets to write them down.