STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 The State Agency (SA) conducted an annual recertification survey, and a Complaint Investigation (CI MS# 23999), at the facility from 2/11/24 through 2/20/24. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid and cited F580, F600, F604, F641, F656, F658, F677, F684, F692, F695, F700, F726, F759, F760, F801, F835, F851, F865, F880, and F919. The SA investigated the complaints related to resident abuse and misappropriation of property and cited F610, F759, and F760. The State Agency (SA) identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 11/02/23 when the facility failed to recognize, evaluate, and address Resident #13's nutritional needs, which resulted in an unintended significant weight loss of 6.92% (percent) in one (1) month, which further led to a significant weight loss of 17.52% (percent) in four (4) months. The facility's failure to consult a Registered Dietician (RD), notify the attending physician of a significant change in condition, and act upon the residents' weight loss, placed the resident, and all other residents residing in the facility at risk for serious harm, serious injury, serious impairment, and possibly death. The IJ and SQC existed at: 42 CFR §483.12 Freedom from Abuse, Neglect, and Exploitation - F600 - Scope/Severity (S/S) "K" 42 CFR §483.25(g)(1) Nutrition/Hydration Status Maintenance - F692- S/S "J"	F 000		

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

Electronically Signed | 03/14/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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	Continued From page 1	F 000		

IJ existed at:

42 CFR §483.10(g)(14)(B) Notification of Changes - F580 - S/S "J"

42 CFR §483.21(b)(1) Comprehensive Care Plans - F656 - S/S "J"

42 CFR §483.70 Administration - F835- S/S "K"

42 CFR §483.75(a) Quality Assurance and Performance Improvement (QAPI) Program - F865 - S/S "J"

The facility Administrator was notified of the IJ and SQC on 2/13/24 at 4:30 PM and presented with the IJ Templates.

The facility provided an acceptable Removal Plan on 2/14/24, in which they alleged all corrective actions to remove the IJ were completed on 2/13/24 and the IJ removed on 2/14/24.

The SA validated the Removal Plan on 2/20/24 and determined the IJ was removed on 2/14/24, prior to exit. Therefore, the scope and severity for 42 CFR §483.10(g)(14) Notification of Changes (F 580), 42 CFR §483.21(b)(1) Comprehensive Care Plans (F656), 42 CFR §483.25(g)(1) Nutrition/Hydration Status Maintenance (F692), and 42 CFR §483.75(a) Quality Assurance and Performance Improvement (QAPI) Program (F 865) were lowered from a "J" to a "D" and 42 CFR §483.12 Freedom from Abuse, Neglect, and Exploitation (F 600) and 42 CFR §483.70 Administration (F835) were lowered from a "K" to an "E" while the facility develops a plan of correction to monitor the effectiveness of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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	Continued From page 2 systemic changes to ensure the facility sustains compliance with regulatory requirements. The census at the time of survey was 60, and the facility held a license for 66 beds.	F 000		
F 580 SS=J	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or	F 580		3/19/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 580	Continued From page 3 (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, record review and facility policy review, the facility failed to notify the physician for a significant change in condition for two (2) of six (6) residents sampled for nutrition Resident #20 and Resident #13 as evidenced by: 1) failed to recognize, evaluate, communicate, and address a resident's nutritional needs, which resulted in an unintended significant weight loss of 6.92% (percent) in one (1) month, which further led to a significant weight loss of 17.52% (percent) in four (4) months. Resident #13. The facility's failure to notify the attending physician of a significant change in condition, and act upon the residents' weight loss, placed the resident, and all other residents residing in the facility at risk for serious harm, serious injury, serious impairment, or possible death.	F 580	1. On 02/11/2024, antiemetic medication was ordered for resident #20. On 2/13/2024, In-service for Abuse and Neglect for staff began by the Assistant Director of Nursing. On 02/13/2024, Social Services and Medical Records Nurse interviewed all residents for nausea and vomiting and reported to provider. On 02/13/2024, the Director of Nursing notified providers of residents with complaints of nausea and vomiting. On 02/13/2024, all residents were audited for weight loss by the Director of Nursing, Regional Nurse Consultant, and Minimum Data Set Nurse. On 02/13/2024, Providers for all residents with weight loss were notified by the Director of Nursing, Assistant Director of Nursing, and Medical Records Nurse. On 02/13/2024, a medication review for all residents with	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 580	Continued From page 4 2) failed to identify, communicate, and address a resident at risk for malnutrition due to prolonged nausea and vomiting, and failure to identify a decrease in food intake due to pain and nausea resulted in an unintended significant weight loss of 40.5 pounds in six (6) months. Resident #20. The facility's failure to notify the attending physician of a significant change in condition, and address the residents' prolonged symptoms of nausea and vomiting, and decreased food intake placed the resident and all other residents residing in the facility at risk for serious harm, serious injury, serious impairment, or possible death. The facility's failure also resulted in a functional decline for Resident #20, which potentially resulted in the resident's admission to hospice services on 2/14/24. The State Agency (SA) identified an Immediate Jeopardy (IJ) that began on 11/02/23 when the facility failed to recognize, evaluate, and address Resident #13's nutritional needs, which resulted in an unintended significant weight loss of 6.92% (percent) in one (1) month, which further led to a significant weight loss of 17.52% (percent) in four (4) months. The IJ existed at: 42 CFR §483.10(g)(14) Notification of Changes - F580 - Scope/Severity "J" The facility Administrator was notified of the IJ on 2/13/24 at 4:30 PM and provided the IJ Template. The facility provided an acceptable Removal Plan on 2/14/24, in which they alleged all corrective actions to remove the IJ were completed on 2/13/24 and the IJ removed on 2/14/24.	F 580	weight loss was conducted by the medical director. On 02/13/2024, Dietary Manager and Minimum Data Set Nurse audited all Registered Dietician Recommendations for the last 90 days were reviewed with provider and new orders and implemented. On 02/13/2024, all nutrition care plans were audited by the Minimum Data Set Nurse and updated to reflect dietary recommendations. Ad Hoc Quality Assurance and Performance Improvement meeting was held on 02/13/2024. On 02/13/2024, One-on-One in-services with the Director of Nursing, Dietary Manager, Assistant Director of Nursing, Medical Records Nurse, and Minimum Data Set Nurse regarding weights, care plans, notifying physician, Quality Assurance and Performance Improvement meetings, Registered Dietitian Recommendations, Documentation, and Administration were conducted by the Regional Nurse Consultant. On 02/13/2024, the Regional Director of Operations conducted and One-on-One in-service with the Administrator regarding weights, care plans, notifying physician, Quality Assurance and Performance Improvement meetings, Registered Dietitian Recommendations, Documentation, and Administration. On 02/13/2024, nurses who provided care to resident # 20 for previous three weeks were provided one-on-one for reporting changes of condition to provider, documentation, and following plan of care and provided posttest to confirm understanding by the Director of Nursing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 580	Continued From page 5 The SA validated the Removal Plan on 2/20/24 and determined the IJ was removed. Therefore, the scope and severity for 42 CFR §483.10(g)(14) Notification of Changes - F580, was lowered from a "J" to a "D" while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings Include: Record review of the facility policy titled "Change in a Resident's Condition or Status" with a review date of 7/24/23 revealed, "Policy Statement: Our facility notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status...Policy interpretation and Implementation: 1. The nurse will notify the resident's attending physician or physician on call when there has been a (an): ... c. adverse reaction to a medication; d. significant change in the resident's physical/emotional/mental condition; e. need to alter the resident's medical treatment significantly; ... i. specific instruction to notify the physician of changes in the resident's condition..." Resident #20 Cross reference F600, F692 On 2/11/24 at 3:19 PM, an observation and interview with Resident #20 revealed her lying in a fetal position at the foot of the bed. The room was dark upon entrance and the door to her room was closed, and a garbage can was located on the floor beside the resident and she stated she was sick to her stomach. She had a washcloth in her hand and was wiping her face which was	F 580	and Assistant Director of Nursing. On 02/14/2024, resident #20 was ordered appetite stimulant. On 02/14/2024, Resident #20 was admitted to hospice services. On 2/15/2024 resident #13 ordered fortified cereal and fortified mashed potatoes. 2. All residents in the facility have the potential to be affected by the alleged negligent practices. 3. Starting 02/13/2024 and completed by 03/18/2024, licensed nurses will be in-serviced on notifying provider of changes in condition with posttest to confirm understanding by Director of Nurses. Starting 03/07/2024 and completed by 03/08/2024, the Rehab Director in-serviced therapy staff to notify nurse of changes in resident conditions and concerns promptly. 4. Starting 02/13/2024, the Director of Nursing will review progress notes 5 times per week for changes in resident condition and provider notification for 4 weeks then weekly for 4 weeks, then bi-weekly x 2 months, then monthly x 2 months. Any issues will be immediately corrected. The Director of Nurses will report results of the audit to Quality Assurance Performance Improvement Committee (QAPI) monthly x six months starting 03/19/2024 and as needed for review and/or revision.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 580	Continued From page 6	F 580		

observed as pale, lips were dry, and she was thin in appearance.

On 2/12/24 at 8:29 AM, an observation of Resident #20 revealed her lying on her right side in bed with a garbage can located on the floor, close by the resident. The breakfast tray was located on the bedside table untouched. CNA #2 entered the resident's room, and stated the resident refused to eat or drink due to nausea. CNA #2 removed the tray cover, and the resident began to retch and vomited a small amount of clear substance. The resident was weak and pale, and her lips were dry.

On 2/12/24 at 8:35 AM, in an interview with CNA #2 revealed she had worked at the facility for three (3) weeks and Resident #20 had refused to eat or drink everyday that she had been here since then. She explained that the resident had been nauseated, dry heaving, and vomiting for the past three (3) weeks, since she had been employed at the facility. She confirmed that she had reported the symptoms to the medication nurse every day that she worked.

Record review of Resident #20's "Progress Notes" from 11/01/23 through 2/11/24, revealed there was not any documentation that the resident had nausea and vomiting or that she refused meals.

Record review of the "Occupational Therapy Progress Notes" dated 2/01/24 revealed, "Patient refused: pt (patient) is refusing to eat and has poor appetite. pt (patient) c/o (complains of) nausea almost every day, but is not eating even with max encouragement and assist from therapist." ... Also revealed under, "Assessment

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 580	Continued From page 7	F 580		

and Summary of Skilled Services: ... therapist encouraging pt (patient) daily to eat and providing assist, but pt (patient) refuses to eat and c/o (complains of) nausea..."

Record review of the "Order Summary Report" for Resident #20 revealed an order dated 2/11/24 at 1827 (6:27 PM), "Ondansetron HCL (Hydrochloride) Tablet 4 (four) MG (milligrams) Give 1 (one) tablet by mouth every 6 (six) hours as needed for Nausea and Vomiting" ...

Record review of Resident #20's January and February 2024 "Medication Admission Record" (MAR) revealed, there was not a physician's order for nausea/vomiting medication before the new order for Zofran started on 2/11/24, which indicated the resident's symptoms of prolonged nausea and vomiting were left untreated.

Record review of the "Meal Intake Documentation Report" completed by the Certified Nurse Aides (CNAs) revealed, Resident #20 refused eighteen (18) meals from 12/18/23 through 12/31/23. She refused thirty-one (31) meals in the month of January 2024, with a total of thirty-nine (39) meals consumed at 0-25% (percent), and she refused sixteen (16) meals from 2/01/24 through 2/11/24, with a total of fourteen (14) meals consumed at 0-25% (percent).

Record review of Resident #20's weights revealed a significant weight loss of 13.9% (percent) in one (1) month, 21.6% (percent) in three (3) months, and 26.2% (percent) in six (6) months.

Record review of the" Order Summary Report" for Resident #20 revealed an order dated 1/04/24,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 580	Continued From page 8	F 580		

"Regular diet Regular texture, Regular consistency" ... Also revealed an order dated 1/04/24, "Med Pass 2.0 two times a day for supplement."

On 2/11/24 at 3:55 PM, during an interview with the Director of Nursing (DON) revealed Resident #20's condition had declined over the past couple of months related to her diagnosis of dementia. She explained that the resident had a significant decline after she fell in December 2023, and received a fracture of the T-12 vertebrae and had to be placed on strong pain medications. She stated, to her knowledge, the resident had not experienced any nausea and vomiting until yesterday when the Survey Agency brought it to her attention. She stated none of the staff had reported it to her and that she should be aware of what was happening with the resident if something like that was going on. She revealed she was aware that the resident was not eating or drinking and had been refusing meals and stated she had made the physician aware of the resident's decline, and the significant weight loss.

Record review of the "Consultant Registered Dietician (RD) Note" dated 12/27/23, for Resident #20 revealed the RD (Registered Dietician) recommended, "Med Pass 2 oz (ounces) BID (twice daily), weekly weights x (times) 4 (four) weeks, and add Fortified Pudding BID (twice daily) at lunch and dinner..."

Record review of the "Consultant Registered Dietician (RD) Note" dated 1/5/24, for Resident #20 revealed, "Resident w/(with) significant wt (weight) loss x (times) 1 (one) mo (month) (-9%) and x (times) 6 (six) mo (months) (-13.7%) (percent). Po (by mouth) intake likely not meeting

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 580	Continued From page 9	F 580		

nutritional needs. Resident is at risk for skin breakdown and wt (weight) loss d/t (due to) decreased appetite ... NO N/V/c/D (nausea, vomiting, complaints of diarrhea) documented." ... Also revealed under REC (recommendations): "Resident may benefit from an appetite stimulant, please document % (percentage) of supplement consumed daily, add fortified pudding BID (twice daily) at lunch and dinner, weekly weights x (times) 4 (four) weeks to assure stable weight" ...

Record review of the "Consultant Registered Dietician (RD) Note) dated 2/10/24, for Resident #20 revealed, "Resident w/(with) significant wt (weight) loss x times 1 (one) mo (month), x (times) 3 (three) mo (months) and x (times) 6 (six) mo (months) ... consuming <25% w/(with) refusals of meals ... Po (by mouth) intake likely not meeting nutritional needs ... NO N/V/c/D (nausea, vomiting, complaints of diarrhea) documented." ... Also revealed under REC (recommendations): "Resident may benefit from an appetite stimulant, please document % of supplement consumed daily, weekly weights x 4 weeks to assure stable weight, if po (by mouth) intake and wt (weight) status does not improve, resident may benefit from an alternate means of nutrition support."

Record review of the "Order Summary Report" for Resident #20 revealed there was not a physician's order for fortified pudding at lunch and supper or a medication to stimulate appetite per Registered Dietician (RD) recommendations.

On 2/11/24 at 4:20 PM, an interview with Licensed Practical Nurse (LPN) #3 revealed Resident #20 had a decline over the past several weeks. She explained that the resident would not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 580	Continued From page 10	F 580		

eat or drink, including the med pass supplement. She stated that usually they cannot get her to take her medications and that the resident would eat crushed ice chips, but that was about it. LPN #3 explained that she noticed a change after the resident fell and hurt her back and she was in a lot of pain and she confirmed that she had not notified the resident's physician of the change in the resident's condition.

On 2/12/24 at 6:05 PM, a telephone interview with Medical Director revealed the staff had contacted him last night regarding Resident #20 having nausea and vomiting, and he had ordered Zofran as needed. He confirmed that the staff had not contacted him or made him aware of the residents' decline in condition or her refusal to eat or drink. He stated that he was not notified of her significant weight loss (40.5 pounds in 6 months) or the Registered Dietician (RD) recommendations. He confirmed Resident #20's current condition was serious and stated "What you have relayed screams neglect."

Record review of Resident #20's Physician Nursing Home Visit dated 1/26/24 revealed, "No concerns reported by the nursing staff ...." The physician progress note did not identify any documentation to support the resident's nausea and vomiting or weight loss.

On 2/13/24 at 8:13 AM, an interview with the Dietary Manager (DM) revealed Resident #20 did not have a physician's order for fortified pudding, and to her knowledge, had never been started on an appetite stimulate. She explained that the facility had trouble getting the RD recommendations and that she just realized last week on Friday 2/9/24 that they were going to her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 580	Continued From page 11	F 580		

spam email. She confirmed that lack of implementation of the RD recommendations could cause the resident to have weight loss and malnourishment.

On 2/13/24 at 10:38 AM, an interview with the Director of Nursing (DON) confirmed after reviewing Resident #20's progress notes, she observed there was no documentation to support a decline and there was no documentation to show the Medical Director had been notified. She revealed before the fall the resident was ambulatory, rarely in bed, and she took herself to the bathroom. She stated she would sit up in a chair in her room and after the fall the resident required more help with her Activities of Daily Living (ADLs), stayed in bed, became incontinent, had more falls, and required the staff to assist with eating. She confirmed that the facility should have notified the physician immediately when the decline came about, and verbalized that was a failure on their part. The DON stated that the facility did not reach out to the physician to inquire about drawing labs or starting any intravenous fluids throughout these months of the resident refusing to eat or drink. She stated that she did report the weight loss to the physician while he was inside the facility and stated, "I do not recall the date or month I notified him." She confirmed that she did not have documentation to support her notification.

On 2/13/24 at 2:10 PM, an interview with the Administrator (ADM) revealed Resident #20's weight loss had been discussed in January 2024 during a PAR (patients at risk) meeting. The ADM confirmed that the Dietary Recommendations for Resident #20 had not been implemented and that the facility failed to document the significant

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 580	Continued From page 12	F 580		

changes that occurred in the resident's condition. She stated, "I know the documentations not there." She revealed that she was told the DON had reached out to the physician and stated, "It looks bad on our part."

Record review of the "Progress Notes" for Resident #20 dated 2/14/24, "Proper Name Hospice consulted per MD (medical doctor) order and family request ... for declining condition related to Alzheimer's disease ..."

Record review of the "Transfer/Discharge Report" revealed the facility admitted Resident #20 on 1/24/22 with medical diagnoses that included Alzheimer's disease, Rheumatoid Arthritis, and Wedge compression fracture of T 11-T 12 vertebra, subsequent encounter for fracture with delayed healing.

Record review of Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 01/10/24 revealed a Brief Interview for Mental Status (BIMS) of 03 which indicated the resident had severe cognitive impairment. Prior MDS's dated 09/18/23 revealed a BIMS of 11, MDS dated 12/11/23 revealed a BIMS of 9.

Resident #13 Cross reference F600, F692

On 2/13/24 at 11:05 AM, during an observation and interview Resident #13, lying in bed, stated she had lost weight while in the facility. She revealed there were times she did not eat well and she was not on supplements.

On 2/14/24 at 11:40 AM, during an interview the DON confirmed Resident #13 had a significant weight loss which was not reported to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 580	Continued From page 13	F 580		

physician, therefore, no interventions to prevent and treat the nutritional status concerns were ordered and her weight continued to decrease. She confirmed the facility's failure to notify Resident #13's physician led to a 6.92% weight loss during her first month at the facility and to a 17.52% weight loss during her first four months at the facility.

On 2/15/24 at 8:45 AM, an interview with the facility's Regional Nurse Consultant confirmed the facility neglected to identify a nutritional concern and to notify the physician of a significant weight loss, therefore, no interventions to prevent adverse consequences were ordered and the resident's weight continued to decline.

Record review of Resident #13's Admission Record revealed she was admitted to the facility on 10/2/23. Diagnoses included Stevens-Johnson Syndrome, Non-pressure ulcers, Anxiety Disorder, Major Depressive Disorder.

Record review of Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 12/12/23 revealed a BIMS score of 12 which indicated the resident had a moderate cognitive impairment.

The facility submitted the following removal plan:

On 02/13/2024 at 4:30 PM the Mississippi State Department of Health (MSDH) state survey team notified the Administrator of an Immediate Jeopardy for failing to ensure processes were in place to review and implement Registered Dietician (RD) recommendations, notify the physician of weight loss, and implement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 580	Continued From page 14	F 580		

interventions to address weight loss for Resident #20, who had lost 40.5lbs in the last six months. Resident #20 also had nausea and vomiting and was not eating or drinking adequately for the last three weeks and the facility had failed to notify the physician of the significant change. The facility failed to follow care plan interventions to identify weight loss and address weight loss for Resident #20. The facility failed to have an effective Quality Assurance and Performance Improvement (QAPI) meeting to ensure all recommendations from the Registered Dietician were addressed in a prompt manner. Review of facility processes revealed that the recommendations from the registered dietician was being sent to the Dietary Manager via email and the emails were not received and not presented to the interdisciplinary team and reviewed by the provider and implemented. Interview with staff indicates that resident has had poor appetite since January, and it was not documented in the medical record.

On 02/11/2024 at 6:27 PM, the facility nurse notified the provider and obtained orders for anti-emetic.

On 2/12/2024 at 9:27 am, the facility attempted to transfer resident to the emergency room for evaluation and treatment as indicated. The Responsible Party refused for resident to be sent to the emergency room on this date. The facility obtained a physician's order for hospice services.

On 02/13/2024 5:00 PM, In-services began on Abuse and Neglect for all staff by the Assistant Director of Nursing. All staff will be trained prior to returning to work. In-services began by Assistant Director of Nursing on Documentation, Provider Notification, and Change of Condition. All staff will

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 580	Continued From page 15	F 580		

be trained prior to returning to work.

On 02/13/2024 at 5:15 PM, Social Services and Medical Records Nurse interviewed all residents regarding Nausea and Vomiting to ensure all significant changes of conditions were reported to the providers. It was noted upon interview that nine (9) residents reported recent complaints of nausea and vomiting, one (1) resident noted to have yellow discharge from mouth and nose, 1 resident was unable to recall when nausea or vomiting occurred with no staff being knowledgeable of nausea or vomiting, two (2) residents reported nausea or vomiting after eating, 2 residents reported not having appetite or eating, 1 resident reported nausea but did not report to nurse, 2 residents reported nausea and medications received.

On 02/13/2024 at 5:30 PM, all residents were audited for weight loss by the Director of Nursing, Regional Nurse Consultant, and Minimum Data Set Nurse. Results of weight loss audit were reviewed by the medical director (15 unplanned weight losses, 1 planned) and new orders and diagnoses were provided by the medical director. All nutrition care plans audited by Minimum Data Set Nurse on 02/13/2024 with 5 residents whose registered dieticians' recommendations were not on care plans, dietary recommendations reviewed with providers and orders received per providers.

On 02/13/2024 at 6:05 PM, the Director of Nursing notified the physician of all 9 residents, notified the Institutional Specialized Needs Plan (ISNP) nurse practitioner of all residents (4) and hospice of all residents (1) with Nausea and Vomiting with new orders received from provider. 1 resident reviewed with new orders for chest

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 580	Continued From page 16	F 580		

x-ray due to cough, congestion, and yellow discharge from mouth and nose, 2 residents were ordered medications for reflux, 1 resident noted to be receiving antibiotics and has orders in place for anti-emetic medications, 1 resident reported abdominal pain and MD was notified and seen resident on 02/12/2024 with new orders for stool softener, 1 resident noted to have diarrhea and has been antibiotics new orders received for Zofran and anti-diarrheal, 1 resident noted to have weight loss and nausea and vomiting new orders received on 2/11/2024 to start Zofran and start peri-actin the family was not agreeable to start peri-actin and wanted to wait to speak to hospice on 02/14/2024, 2 residents did not report nausea to nurses at time of occurrence.

On 02/13/2024 at 6:59 PM, Social Services and Medical Records nurse interviewed residents with BIMS 10 or higher to ensure feeling of safe and are free of health concerns, no health or safety concern during interviews.

On 02/13/2024 at 8:30 PM, all Registered Dietician recommendations for last 90 days audited by Dietary Manager and Minimum Data Set Nurse with 5 residents whose registered dietician recommendations were not addressed. All Dietary recommendations reviewed with the Medical Director (5) and subsequent providers as appropriate Hospice (2 residents who have been on hospice services prior to survey entrance) and Institutional Special Needs Program nurse practitioner (1), new orders received from providers as appropriate.

On 02/13/2024 at 8:40 PM, All nutrition care plans audited by Minimum Data Set Nurse with 5 residents whose registered dieticians'

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 580	Continued From page 17	F 580		

recommendations were not on care plans, dietary recommendations reviewed with providers and orders received per providers and care plans updated.

On 02/13/2024 at 9:00 PM, all residents noted with weight loss were reviewed with the Medical Director, the Medical Director performed medication review on all residents with weight loss.

Ad Hoc QAPI was held on 02/13/2024 at 10:15 PM with the Medical Director via phone, Administrator, Director of Nursing, Social Services, Minimum Data Set Nurse, Life Connections Coordinator, Regional Nurse Consultant, Regional Director of Operations, Assistant Director of Nursing, Registered Nurse Supervisor, Dietary Manager, and Medical Records Nurse. The Minimum Data Set Nurse has been designated as the Quality Assurance Nurse with responsibility reviewing all audits, Performance Improvement Plans, Quality Measures, and actively participating in the Quality Assurance and Performance Improvement meetings. All areas of deficiencies were reviewed in Ad-Hoc Quality Assurance and Performance Improvement meeting. Medical Records nurse or Assistant Director of Nursing will be responsible for receiving Registered Dietician recommendations, reviewing with providers, entering orders, and progress notes. New processes for Medical Director to review facility weight losses each week on visit, Registered Dietitian recommendations to be reviewed weekly with the Interdisciplinary Team and the Medical Director by Friday, in the event Registered Dietician recommendations are not received, the medical director will be notified. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 580	Continued From page 18	F 580		

Dietary Manager will review the weight and vital sign exception report and present findings in the clinical meeting. The Director of Nursing will review weights and registered dietician recommendations. The Director of Nursing will review progress notes daily. The administrator will review the audit findings weekly. All results will be reviewed in Quality Assurance and Performance Improvement meetings.

On 02/13/2024 at 10:00 PM, One-on-one Inservice conducted with Administrator by the Regional Director of Operations for weights, care plans, Quality Assurance and Performance Improvement, Notifying Physicians, Registered Dietician Recommendations, Documentation, and Administration Processes. The Regional Nurse Consultant conducted one-on-one in-services with the Director of Nursing, Dietary Manager, Assistant Director of Nursing, Medical Records Nurse, and Minimum Data Set Nurse regarding weights, care plans, Quality Assurance and Performance Improvement, Notifying Physicians, Registered Dietician Recommendations, Documentation and Administration Processes. One-on-one in-service conducted with the Dietary Manager by the Administrator regarding Communication of Dietary Recommendations, Review of Recommendations, and reporting any identified areas of concerns with Dietary Recommendations. All nurses who provided care to resident #20 for the previous 3 weeks were provided One-on-one in-services regarding reporting changes of condition to provider, documentation, and following plan of care then were provided with a post-test to confirm understanding of one-on-one in-services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 580	Continued From page 19	F 580		

As of 02/14/2024, the facility alleges compliance. All corrective action completed on 02/13/2024.

The Survey Agency (SA) validated the facility's Corrective Actions on 2/20/24:

The SA validated through record review that Resident #20 was ordered an anti-emetic for nausea/vomiting.

The SA validated through interview and record review that in-services were conducted for Abuse and neglect, documentation, provider notification, and change of condition. No staff can return to work until they have received in-services.

The SA validated through record review that all residents were interviewed and screened for symptoms of nausea and vomiting and the physician was notified of the findings with physician orders if appropriate.

The SA validated through record review and staff interview that all residents were audited for weight loss and the Medical Director was updated. All nutrition care plans were audited and updated with dietary recommendations.

The SA validated through record review that all residents with a Brief Interview for Mental Status (BIM's) of 10 or higher were interviewed to ensure feeling safe in their environment and free from health concerns.

The SA validated through record review that all Registered Dietician (RD) recommendations were audited and addressed with the provider as appropriate.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 580	Continued From page 20 The SA validated the Medical Director reviewed the resident with weight loss and performed medication review. The SA validated through staff interview and record review on 2/20/24 that an Emergency Quality Assurance and Performance Improvement (QAPI) meeting was conducted on 2/13/24 with all members in attendance. The SA validated through record review and staff interview that one-on-one in-services were conducted on weights, care plans, Quality Assurance and Performance Improvement (QAPI), notifying physicians, reporting changes, Registered Dietician Recommendations, Documentation, and Administrative Processes. No staff can return to work until they have received in-services. The SA validated on 02/20/24 that all corrective actions were completed on 2/13/24 and the IJ (Immediate Jeopardy) was removed as of 2/14/24.	F 580		
F 600 SS=K	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.	F 600		3/19/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 600	Continued From page 21 §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, record review, and facility policy review, the facility failed to protect a residents right to be free from neglect for two (2) of three (3) residents sampled for abuse, Resident #13 and Resident #20 as evidence by: 1) neglected to recognize, communicate, evaluate, and address a resident's nutritional needs, which resulted in an unintended significant weight loss of 6.92% (percent) in one (1) month, which further led to a significant weight loss of 17.52% (percent) in four (4) months. Resident #13. The facility's failure to consult a Registered Dietician (RD), notify the attending physician of a significant change in condition, and act upon the residents' weight loss, placed the resident, and all other residents residing in the facility at risk for serious serious harm, serious injury, serious impairment, or possibly death. 2) neglected to identify, communicate, and address a resident at risk for malnutrition due to prolonged nausea and vomiting, and failure to identify a decrease in food intake due to pain and nausea resulted in an unintended significant weight loss of 40.5 pounds in six (6) months. Resident #20. The facility's failure to implement a Registered Dietician (RD) recommendation, notify the attending physician of a significant change in condition, and address the residents' prolonged symptoms of nausea and vomiting, and	F 600	1. On 02/11/2024, antiemetic medication was ordered for resident #20. On 2/13/2024, In-service for Abuse and Neglect for staff began by the Assistant Director of Nursing. On 02/13/2024, Social Services and Medical Records Nurse interviewed all residents for nausea and vomiting and reported it to the provider. On 02/13/2024, the Director of Nursing notified providers of residents with complaints of nausea and vomiting. On 02/13/2024, all residents were audited for weight loss by the Director of Nursing, Regional Nurse Consultant, and Minimum Data Set Nurse. On 02/13/2024, Providers for all residents with weight loss were notified by the Director of Nursing, Assistant Director of Nursing, and Medical Records Nurse. On 02/13/2024, a medication review for all residents with weight loss was conducted by the medical director. On 02/13/2024, Dietary Manager and Minimum Data Set Nurse audited all Registered Dietician Recommendations for the last 90 days were reviewed with provider and new orders and implemented. On 02/13/2024, all nutrition care plans were audited by the Minimum Data Set Nurse and updated to reflect dietary recommendations. Ad Hoc Quality Assurance and Performance Improvement meeting was held on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 600	Continued From page 22 decreased food intake placed the resident and all other residents residing in the facility at risk for serious harm, serious injury, serious impairment, or possibly death. The facility's neglect also resulted in a functional decline for Resident #20, which potentially resulted in the resident's admission to hospice services on 2/14/24. The State Agency (SA) identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 11/02/23 when the facility failed to recognize, evaluate, and address Resident #13's nutritional needs, which resulted in an unintended significant weight loss of 6.92% (percent) in one (1) month, which further led to a significant weight loss of 17.52% (percent) in four (4) months. The facility's failure to consult a Registered Dietician (RD), notify the attending physician of a significant change in condition, and act upon the residents' weight loss, placed the resident, and all other residents residing in the facility at risk for serious negative outcomes. The IJ and SQC existed at: 42 CFR §483.12 Freedom from Abuse, Neglect, and Exploitation - F600 - Scope/Severity "J" The facility Administrator was notified of the IJ and SQC on 2/13/24 at 4:30 PM and provided the IJ Template. The facility provided an acceptable Removal Plan on 2/14/24, in which they alleged all corrective actions to remove the IJ were completed on 2/13/24 and the IJ removed on 2/14/24. The SA validated the Removal Plan on 2/20/24 and determined the IJ was removed on 2/14/24.	F 600	02/13/2024. On 02/13/2024, One-on-One in-services with the Director of Nursing, Dietary Manager, Assistant Director of Nursing, Medical Records Nurse, and Minimum Data Set Nurse regarding weights, care plans, notifying physician, Quality Assurance and Performance Improvement meetings, Registered Dietitian Recommendations, Documentation, and Administration were conducted by the Regional Nurse Consultant. On 02/13/2024, the Regional Director of Operations conducted and One-on-One in-service with the Administrator regarding weights, care plans, notifying physician, Quality Assurance and Performance Improvement meetings, Registered Dietitian Recommendations, Documentation, and Administration. On 02/13/2024, nurses who provided care to resident # 20 for previous three weeks were provided one-on-one for reporting changes of condition to provider, documentation, and following plan of care and provided posttest to confirm understanding by the Director of Nursing and Assistant Director of Nursing. On 02/13/2024, Social Services and Medical Records nurse interviewed residents with a BIMS of 10 or higher to ensure residents were feeling safe in the environment and are free of health and safety concerns. On 02/14/2024, resident #20 was ordered appetite stimulant. On 02/14/2024, Resident #20 was admitted to hospice services. On 2/15/2024, resident #13 was ordered fortified cereal and fortified mashed potatoes.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 600	Continued From page 23 Therefore, the scope and severity for 42 CFR §483.12 Freedom from Abuse, Neglect, and Exploitation - F600, was lowered from a "J" to a "D" while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings Include: Review of the facility policy titled "Abuse, Neglect, Exploitation and Misappropriation Prevention Program" with a revision date of 10/22 revealed, "Policy Statement: Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraints not used to treat the resident ' s symptoms...Policy Interpretation and Implementation: The resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives: 1. Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including, but not necessarily limited to a. facility staff; ... 2. Develop and implement policies and protocols to prevent and identify:... neglect of residents;..." Resident #20 Cross reference F580, F656, F692 During an observation and interview with Resident #20 on 2/11/24 at 3:19 PM, revealed her lying in a fetal position at the foot of the bed. Upon entrance to the room the door was closed, the room was dark and it was observed that a garbage can was located on the floor beside the	F 600	2. All residents in the facility have the potential to be affected by the alleged negligent practices. 3. A new Registered Dietician (RD) was placed in the facility on 03/07/2024. Meal intake percentages will be monitored by Medical Records starting on 02/13/2024 in clinical meeting weekly. Beginning on 02/13/2024 all dietary recommendations will be reviewed by the Dietary Manager and the Director of Nurses weekly. Starting 02/13/2024, Medical Records will ensure that all dietary recommendations are completed and followed though. Staff were in-serviced with a post test on abuse, neglect and misappropriation beginning on 02/13/2024 and completed on 03/18/2024 by Assistant Director of Nurses. Starting 02/13/2024 and completed on 03/18/2024, licensed nurses educated on notifying provider of changes in condition with posttest to confirm understanding by Director of Nurses. Starting 03/07/2024 and completed on 03/08/2024, the Rehab Director in-serviced therapy staff to notify nurse of changes in resident conditions and concerns promptly. 4. Starting 02/13/2024, the Medical Records Nurse will review dietary recommendations weekly and ensure follow through weekly x 4 weeks then monthly x 3 months. The Medical Records Nurse will report the findings to the Quality assurance and performance improvement committee (QAPI) for review and or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 600	Continued From page 24 resident. The resident stated she was sick to her stomach and she had a washcloth in her hand and was wiping her face. The resident 's color was pale, lips were dry, and she was thin in appearance. During an observation and interview with Resident #20 on 2/11/24 at 6:07 PM, revealed her lying on her right side in bed. The resident stated she was nauseated and could not eat dinner and stated, "I'm just sick." During an observation of Resident #20 on 2/12/24 at 8:29 AM, revealed her lying on her right side in bed. The garbage can was located on the floor, close by the resident. The breakfast tray was located on the bedside table untouched. CNA #2 entered the resident's room, and stated the resident refused to eat or drink due to nausea. CNA #2 removed the tray cover, and the resident began to retch and vomited a small amount of clear substance into the garbage can. The resident was observed as weak and pale, and her lips were dry. During an interview with CNA #2 on 2/12/24 at 8:35 AM, revealed she had worked at the facility for three (3) weeks and Resident #20 had refused to eat or drink everyday since then. She explained that the resident had been nauseated, dry heaving, and vomiting for the past three (3) weeks, that she had been employed at the facility. She confirmed that she had reported the symptoms to the medication nurse every day that she worked. Record review of Resident #20's "Progress Notes" from 11/01/23 through 2/11/24, revealed there was not any documentation that the	F 600	revision monthly starting 03/19/2024. Starting 03/04/2024, the Administrator will interview 5 (five) alternating residents weekly to ensure that residents feel safe and are free of health and safety concerns for 8 weeks, then bi-weekly for 2 months, then monthly for 2 months. The administrator will take immediate corrective action as needed and notify appropriate authorities as needed. The Administrator will report the findings to the Quality assurance and performance improvement committee (QAPI) for review and or revision monthly, starting on 03/19/2024 for 6 months then as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 600	Continued From page 25	F 600		

resident had nausea and vomiting or that she refused meals.

Record review of the "Occupational Therapy Progress Notes" dated 2/01/24 revealed, "Patient refused: pt (patient) is refusing to eat and has poor appetite. pt (patient) c/o (complains of) nausea almost every day, but is not eating even with max encouragement and assist from therapist." ... Also revealed under, "Assessment and Summary of Skilled Services: ... therapist encouraging pt (patient) daily to eat and providing assist, but pt (patient) refuses to eat and c/o (complains of) nausea..."

Record review of the "Order Summary Report" for Resident #20 revealed an order dated 2/11/24 at 1827 (6:27 PM), "Ondansetron HCL (Hydrochloride) Tablet (Zofran) 4 (four) MG (milligrams) Give 1 (one) tablet by mouth every 6 (six) hours as needed for Nausea and Vomiting" ...

Record review of Resident #20's January and February "Medication Admission Record" (MAR) revealed, there was not a physician ' s order for nausea/vomiting medication before the new order for Zofran started on 2/11/24, which indicated the resident's symptoms of prolonged nausea and vomiting were left untreated.

Record review of the "Meal Intake Documentation Report" completed by the Certified Nurse Aides (CNAs) revealed, Resident #20 refused eighteen (18) meals from 12/18/23 through 12/31/23. She refused thirty-one (31) meals in the month of January 2024, with a total of thirty-nine (39) meals consumed at 0-25% (percent), and she refused sixteen (16) meals from 2/01/24 through

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 600	Continued From page 26	F 600		

2/11/24, with a total of fourteen (14) meals consumed at 0-25% (percent).

Record review of Resident #20's "Order Summary Report" revealed an order dated 1/08/24, "Weekly weights x (times) 4 (four) weeks one time a day every 7 day(s)" ...

Record review of Resident #20's weights revealed a significant weight loss of 13.9% (percent) in one (1) month, 21.6% (percent) in three (3) months, and 26.2% (percent) in six (6) months.

Record review of the" Order Summary Report" for Resident #20 revealed an order dated 1/04/24, "Regular diet Regular texture, Regular consistency" ... Also revealed an order dated 1/04/24, "Med Pass 2.0 two times a day for supplement."

During an interview with the Director of Nursing (DON) on 2/11/24 at 3:55 PM revealed Resident #20's condition had declined over the past couple of months. She explained that the resident had a significant decline after she fell in December 2023, and received a fracture of the T-12 vertebrae and had to be placed on strong pain medications. She stated, to her knowledge, the resident had not experienced any nausea and vomiting until yesterday when the Survey Agent brought it to her attention. She stated none of the staff had reported it to her and that she should be aware of what was happening with the resident. She revealed she was aware that the resident was not eating or drinking and had been refusing meals and that she had made the physician aware of the resident's decline, and the significant weight loss, and the Registered Dietician (RD)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 600	Continued From page 27	F 600		

had evaluated her.

An interview with Licensed Practical Nurse (LPN) #3 on 2/11/24 at 4:20 PM, revealed Resident #20 had a decline over the past several weeks. She explained that the resident would not eat or drink anything, including the med pass supplement. She stated that usually they cannot get her to take her medications. She revealed that the resident would eat crushed ice chips, but that's about it. LPN #3 explained that she noticed a change after the resident fell and hurt her back and was in a lot of pain. She confirmed that she had not notified the resident's physician of the change in condition.

During a telephone interview with Medical Director on 2/12/24 at 6:05 PM, revealed the staff had contacted him last night regarding Resident #20 having nausea and vomiting, and he had ordered Zofran as needed. He confirmed that the staff had not contacted him or made him aware of the residents' decline in condition or her refusal to eat or drink. He stated that he was not notified of her significant weight loss (40.5 pounds in 6 months) or the Registered Dietician (RD) recommendations. He confirmed Resident #20's current condition was serious and stated "What you have relayed screams neglect."

Record review of Resident #20's Order Summary Report revealed an order dated 1/08/24, "RD (Registered Dietician) consult" ...

Record review of the "Consultant Registered Dietician (RD) Note" dated 12/27/23, for Resident #20 revealed the RD (Registered Dietician) recommended, "Med Pass 2 oz (ounces) BID (twice daily), weekly weights x (times) 4 (four)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 600	Continued From page 28	F 600		

weeks, and add Fortified Pudding BID (twice daily) at lunch and dinner" ...

Record review of the "Consultant Registered Dietician (RD) Note" dated 1/5/24, for Resident #20 revealed, "Resident w/(with) significant wt (weight) loss x (times) 1 (one) mo (month) (-9%) and x (times) 6 (six) mo (months) (13.7%) (percent). Po (by mouth) intake likely not meeting nutritional needs. Resident is at risk for skin breakdown and wt (weight) loss d/t (due to) decreased appetite ... NO N/V/c/D (nausea, vomiting, complaints of diarrhea) documented." ... Also revealed under REC (recommendations): "Resident may benefit from an appetite stimulant, please document % (percentage) of supplement consumed daily, add fortified pudding BID (twice daily) at lunch and dinner, weekly weights x (times) 4 (four) weeks to assure stable weight" ...

Record review of the "Consultant Registered Dietician (RD) Note) dated 2/10/24, for Resident #20 revealed, "Resident w/(with) significant wt (weight) loss x times 1 (one) mo (month), x (times) 3 (three) mo (months) and x (times) 6 (six) mo (months) ... consuming <25% w/(with) refusals of meals ... Po (by mouth) intake likely not meeting nutritional needs ... NO N/V/c/D (nausea, vomiting, complaints of diarrhea) documented." ... Also revealed under REC (recommendations): "Resident may benefit from an appetite stimulant, please document % of supplement consumed daily, weekly weights x 4 weeks to assure stable weight, if po (by mouth) intake and wt (weight) status does not improve, resident may benefit from an alternate means of nutrition support."

Record review of the "Order Summary Report" for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 600	Continued From page 29	F 600		

Resident #20 revealed there was not a physician's order for fortified pudding at lunch and supper or a medication to stimulate appetite per Registered Dietician (RD) recommendations.

Record review of Resident #20's Physician Nursing Home Visit dated 1/26/24 revealed, "No concerns reported by the nursing staff ...." The physician progress note did not identify any documentation to support the resident's nausea and vomiting or weight loss.

An interview with Licensed Practical Nurse (LPN) #2 on 2/13/24 at 7:45 AM, revealed Resident #20 was not drinking the med pass supplement, and was refusing meals. She stated that the resident had been refusing meals for several weeks and that the resident's family was highly involved with her care, and the resident would report nausea to them, and the family would come and let us know when they were there for a visit. LPN #2 confirmed that there was no documentation in the nurses notes to indicate that the resident had nausea or vomiting.

During an interview with the Dietary Manager (DM) on 2/13/24 at 8:13 AM, revealed that she was new to the role and had been in the position since June 2023. She revealed that the facility had weekly PAR (Patients at Risk) meetings where the weights of the residents were discussed and stated all the department heads attend the meetings. The DM revealed, if a resident should need a RD (Registered Dietician) consult, she would notify the RD after the weekly PAR meeting by texting or calling. She stated that the RD would usually text her back to let her know she had the resident down on her list. She revealed that the RD did not come to the facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 600	Continued From page 30	F 600		

and did all her consultations remotely. She explained that the RD was consulted on Resident #20 in January 2024, but confirmed that she had not seen any RD recommendations since that time. She stated that the resident had never received fortified pudding, and to her knowledge, had never started on an appetite stimulate. She explained that the facility had trouble getting the RD recommendations and that she just realized last week on Friday 2/9/24 that the RD recommendations were going to her spam email. She revealed that she tried to open the email and the email read it was quarantined. She revealed that she told the Director of Nursing (DON) that she was not receiving anything from the RD, and she thought the DON had texted her and took care of it. She confirmed that lack of implementation of the RD recommendations could cause the resident to have further weight loss and malnourishment.

During a telephone interview with the Registered Dietician (RD) on 2/13/24 at 9:56 AM, she stated she was notified in late December that Resident #20 needed to be seen due to a significant weight change. She confirmed that she recommended med pass 2 ounces twice daily as a supplement, weekly weights and fortified pudding added with lunch and dinner. She revealed that she also did a consultation on Resident #20 on 1/5/24 and 2/10/24 and recommended that the resident would benefit from an appetite stimulant. She explained that she emailed all her recommendations to the Administrator (ADM), Director of Nursing (DON), Dietary Manager (DM), and the Regional Nursing Consultant (RNC). She explained that she marked on the recommendations if the physician needed to be contacted for a physician order and confirmed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 600	Continued From page 31	F 600		

that Resident #20's recommendation was marked to contact the physician for an appetite stimulant and adding the fortified pudding. She stated that she was unable to contact the doctor or write orders because she did not have the authority with her contract with the facility. She stated that she had not been contacted by anyone from the facility reporting that they had not received Resident #20's dietary recommendations

During an interview with the DON on 2/13/24 at 10:38 AM, revealed Resident #20 functional status had declined since her fall. She confirmed after reviewing the progress notes, she observed there was no documentation to support a decline, nausea, and vomiting or food refusal. She revealed before the fall the resident was ambulatory, rarely in bed, and she took herself to the bathroom. She revealed that she would sit up in a chair in her room. She stated after the fall the resident required more help with her Activities of Daily Living (ADLs), stayed in bed, became incontinent, had more falls, and required the staff to assist with eating. She confirmed that the facility should have notified the physician immediately when the decline came about, and verbalized that was a failure on their part. She explained that the facility had spoken with the son about placing the resident on hospice today, and he had agreed. She explained that she knew it looked bad that they had consulted hospice, but she stated we had talked to the son before, and he thought she might recover. The DON stated that the facility did not reach out to the physician to inquire about drawing labs or any intravenous fluids throughout these months of the resident refusing to eat or drink and experiencing significant weight loss. She stated that she did report the weight loss to the physician while he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 600	Continued From page 32	F 600		

was inside the facility. She stated, "I do not recall the date or month I notified him," and confirmed that she did not have documentation to support her notification. She stated that the facility was not receiving any of the dietary recommendations, and the Dietary Manager (DM) determined that the emails were going to her junk folder. The DON stated that the RD would also add her notes to the Electronic Medical Record (EMR) and would not tell anyone. The DON revealed that she had never received any emails from the RD, and confirmed that she had not gone into her junk email to search and see if they came to her that way. The DON stated, "I have over 700 junk emails and I do not have time to do that." The DON confirmed that with 60 residents in the facility she should have noticed when she was not getting anything from the RD each month but confirmed that she hadn't noticed.

During an interview with the ADM on 2/13/24 at 2:10 PM, revealed the Registered Dietician (RD) worked remotely, and she had seen her in the facility twice. She revealed that the facility usually communicates with the current RD through email or text messages and confirmed that the last RD recommendation she had received by email was in August 2023. She stated that the Dietary Manager (DM) had received some, but they went to her spam folder encrypted. She revealed in November 2023 she started going into the resident notes and printing out the recommendations. She explained that she had not reached out to the RD herself to follow up. The ADM stated they tried to go over the recommendations in the High-Risk meetings and that Resident #20 had been discussed in January 2024 during a PAR (patients at risk) meeting. The ADM confirmed that the Dietary

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 600	Continued From page 33	F 600		

Recommendations for Resident #20 had not been implemented and that the facility failed to document the significant changes that occurred in the resident's condition. She stated, "I know the documentations not there. It looks bad on our part."

During an interview with Social Services (SS) on 2/13/24 at 3:00 PM, revealed she had reached out to the family of Resident #20 about the functional decline on 1/10/24. She revealed that the son did not want to do hospice at that time and was hoping the resident would perk up. She explained that since then, she followed up with the family and explained that the resident continued to decline and asked them to reconsider hospice services again. The SS confirmed that she was unaware that the physician had not been notified of the significant changes with the resident.

Record review of the "Progress Notes" for Resident #20 dated 2/14/24, "Proper Name Hospice consulted per md (medical doctor) order and family request ... for declining condition related to Alzheimer's disease ..."

During an interview with the Minimum Data Set (MDS) Nurse on 2/14/24 at 5:23 PM, revealed that she did a significant change MDS after Resident #20 fell in December 2023, and after it was identified in the facility's clinical meeting that the resident had a significant weight loss in January 2024. She revealed that after the fall, the resident declined in her ability to get out of bed, and she was no longer able to sit in a chair, which was what the resident liked to do. She explained that the resident experienced increased pain, worsening incontinence and was required to wear

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 600	Continued From page 34	F 600		

a back brace when she was out of the bed. She confirmed that the documentation was absent to support a decline in the resident's condition, and stated she went off what was discussed in the High-Risk meetings. She revealed that she was aware that the resident did not have a physician order for the fortified pudding or an appetite stimulant that was recommended by the Registered Dietician (RD).

Record review of the "Transfer/Discharge Report" revealed the facility admitted Resident #20 on 1/24/22 with medical diagnoses that included Alzheimer's disease, rheumatoid arthritis, primary open-angled glaucoma, and wedge compression fracture of T 11-T 12 vertebra, subsequent encounter for fracture with delayed healing.

Record review of Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 01/10/24 revealed a Brief Interview for Mental Status (BIMS) of 03 which indicated the resident had severe cognitive impairment. Prior MDS's dated 09/18/23 revealed a BIMS of 11, MDS dated 12/11/23 revealed a BIMS of 9.

Resident #13 Cross reference F580, F656, F692

An observation and interview on 2/13/24 at 11:05 AM, Resident #13, lying in bed, stated she had lost weight while in the facility. She revealed there were times she did not eat well and she was not on supplements.

An interview on 2/14/24 at 11:40 AM, the Director of Nursing (DON) revealed Resident #13 had a significant weight loss which was not reported to the physician for interventions, therefore, her weight continued to decrease. She stated the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 600	Continued From page 35	F 600		

Registered Dietician (RD) had not been consulted concerning the significant weight loss. She confirmed that due to the physician and the RD not being notified, the resident had a weight loss that could have possibly been avoided if interventions had been put in place for the resident's nutritional well-being. She confirmed each resident has the right to appropriate care, and the facility failed to provide the needed nutritional care. She confirmed the facility neglected to recognize, evaluate, and address the resident's weights, failed to notify the physician of the weight decline, and failed to consult the RD, therefore, appropriate evaluations and interventions were not ordered or initiated which put the resident at risk for a continued weight loss. She confirmed these failures led to a significant weight loss of 6.92% during Resident #13's first month at the facility and to a 17.52% weight loss during her first four months at the facility.

An interview with the facility's Regional Nurse Consultant on 2/15/24 at 8:45 AM, revealed the physician nor the nurse practitioner were notified of Resident #13's significant weight loss and therefore, no interventions were initiated and weight continued to decline. She stated the initial consult with the Registered Dietician (RD) was on admission due to her wounds and once her weight was trending down, no additional consults were made. She confirmed each resident has the right to receive appropriate care and the facility failed to provide the needed nutritional care for this resident. She confirmed the facility neglected to identify, evaluate, and intervene for nutritional concerns and, therefore, an avoidable weight loss occurred due to the facility's failure to appropriately manage the resident's nutritional

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 600	Continued From page 36	F 600		

needs.

An interview on 2/15/24 at 12:00 PM, the Dietary Manager confirmed she was unaware of the resident's significant weight loss and failed to ensure the Registered Dietician was notified of the weight loss concern.

Record review of "Weights and Vitals Summary" revealed Resident #13's admission weight on 10/3/23 was 166.1 pounds and a weight on 11/2/23 was 154.6 pounds which listed a comparison weight of an 11.5 pound decrease and a 6.9% weight loss. Resident #13's weight on 2/5/24 was 137 pounds and compared to the admission weight 4 months previously of 166.1 pounds on 10/3/23 listed a comparison weight of a 29.1 pound decrease and a 17.5% weight loss.

Record review of Resident #13's Admission Record revealed she was admitted to the facility on 10/2/23. Diagnoses included Stevens-Johnson Syndrome, Non-pressure Ulcers, Anxiety Disorder, Major Depressive Disorder.

Record review of Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 12/12/23 revealed a Brief Interview for Mental Status (BIMS) of 12 which indicated the resident had a moderate cognitive impairment.

The facility submitted the following removal plan:

On 02/13/2024 at 4:30 PM the Mississippi State Department of Health (MSDH) state survey team notified the Administrator of an Immediate Jeopardy for failing to ensure processes were in place to review and implement Registered

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 600	Continued From page 37	F 600		

Dietician (RD) recommendations, notify the physician of weight loss, and implement interventions to address weight loss for Resident #20, who had lost 40.5lbs in the last six months. Resident #20 also had nausea and vomiting and was not eating or drinking adequately for the last three weeks and the facility had failed to notify the physician of the significant change. The facility failed to follow care plan interventions to identify weight loss and address weight loss for Resident #20. The facility failed to have an effective Quality Assurance and Performance Improvement (QAPI) meeting to ensure all recommendations from the Registered Dietician were addressed in a prompt manner. Review of facility processes revealed that the recommendations from the registered dietician was being sent to the Dietary Manager via email and the emails were not received and not presented to the interdisciplinary team and reviewed by the provider and implemented. Interview with staff indicates that resident has had poor appetite since January, and it was not documented in the medical record.

On 02/11/2024 at 6:27 PM, the facility nurse notified the provider and obtained orders for anti-emetic.

On 2/12/2024 at 9:27 am, the facility attempted to transfer resident to the emergency room for evaluation and treatment as indicated. The Responsible Party refused for resident to be sent to the emergency room on this date. The facility obtained a physician's order for hospice services.

On 02/13/2024 5:00 PM, In-services began on Abuse and Neglect for all staff by the Assistant Director of Nursing. All staff will be trained prior to returning to work. In-services began by Assistant

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 600	Continued From page 38	F 600		

Director of Nursing on Documentation, Provider Notification, and Change of Condition. All staff will be trained prior to returning to work.

On 02/13/2024 at 5:15 PM, Social Services and Medical Records Nurse interviewed all residents regarding Nausea and Vomiting to ensure all significant changes of conditions were reported to the providers. It was noted upon interview that nine (9) residents reported recent complaints of nausea and vomiting, one (1) resident noted to have yellow discharge from mouth and nose, 1 resident was unable to recall when nausea or vomiting occurred with no staff being knowledgeable of nausea or vomiting, two (2) residents reported nausea or vomiting after eating, 2 residents reported not having appetite or eating, 1 resident reported nausea but did not report to nurse, 2 residents reported nausea and medications received.

On 02/13/2024 at 5:30 PM, all residents were audited for weight loss by the Director of Nursing, Regional Nurse Consultant, and Minimum Data Set Nurse. Results of weight loss audit were reviewed by the medical director (15 unplanned weight losses, 1 planned) and new orders and diagnoses were provided by the medical director. All nutrition care plans audited by Minimum Data Set Nurse on 02/13/2024 with 5 residents whose registered dieticians' recommendations were not on care plans, dietary recommendations reviewed with providers and orders received per providers.

On 02/13/2024 at 6:05 PM, the Director of Nursing notified the physician of all 9 residents, notified the Institutional Specialized Needs Plan (ISNP) nurse practitioner of all residents (4) and hospice of all residents (1) with Nausea and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 600	Continued From page 39	F 600		

Vomiting with new orders received from provider. 1 resident reviewed with new orders for chest x-ray due to cough, congestion, and yellow discharge from mouth and nose, 2 residents were ordered medications for reflux, 1 resident noted to be receiving antibiotics and has orders in place for anti-emetic medications, 1 resident reported abdominal pain and MD was notified and seen resident on 02/12/2024 with new orders for stool softener, 1 resident noted to have diarrhea and has been antibiotics new orders received for Zofran and anti-diarrheal, 1 resident noted to have weight loss and nausea and vomiting new orders received on 2/11/2024 to start Zofran and start peri-actin the family was not agreeable to start peri-actin and wanted to wait to speak to hospice on 02/14/2024, 2 residents did not report nausea to nurses at time of occurrence.

On 02/13/2024 at 6:59 PM, Social Services and Medical Records nurse interviewed residents with BIMS 10 or higher to ensure feeling of safe and are free of health concerns, no health or safety concern during interviews.

On 02/13/2024 at 8:30 PM, all Registered Dietician recommendations for last 90 days audited by Dietary Manager and Minimum Data Set Nurse with 5 residents whose registered dietician recommendations were not addressed. All Dietary recommendations reviewed with the Medical Director (5) and subsequent providers as appropriate Hospice (2 residents who have been on hospice services prior to survey entrance) and Institutional Special Needs Program nurse practitioner (1), new orders received from providers as appropriate.

On 02/13/2024 at 8:40 PM, All nutrition care plans

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 600	Continued From page 40	F 600		

audited by Minimum Data Set Nurse with 5 residents whose registered dieticians' recommendations were not on care plans, dietary recommendations reviewed with providers and orders received per providers and care plans updated.

On 02/13/2024 at 9:00 PM, all residents noted with weight loss were reviewed with the Medical Director, the Medical Director performed medication review on all residents with weight loss.

Ad Hoc QAPI was held on 02/13/2024 at 10:15 PM with the Medical Director via phone, Administrator, Director of Nursing, Social Services, Minimum Data Set Nurse, Life Connections Coordinator, Regional Nurse Consultant, Regional Director of Operations, Assistant Director of Nursing, Registered Nurse Supervisor, Dietary Manager, and Medical Records Nurse. The Minimum Data Set Nurse has been designated as the Quality Assurance Nurse with responsibility reviewing all audits, Performance Improvement Plans, Quality Measures, and actively participating in the Quality Assurance and Performance Improvement meetings. All areas of deficiencies were reviewed in Ad-Hoc Quality Assurance and Performance Improvement meeting. Medical Records nurse or Assistant Director of Nursing will be responsible for receiving Registered Dietician recommendations, reviewing with providers, entering orders, and progress notes. New processes for Medical Director to review facility weight losses each week on visit, Registered Dietitian recommendations to be reviewed weekly with the Interdisciplinary Team and the Medical Director by Friday, in the event

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 600	Continued From page 41	F 600		

Registered Dietician recommendations are not received, the medical director will be notified. The Dietary Manager will review the weight and vital sign exception report and present findings in the clinical meeting. The Director of Nursing will review weights and registered dietician recommendations. The Director of Nursing will review progress notes daily. The administrator will review the audit findings weekly. All results will be reviewed in Quality Assurance and Performance Improvement meetings.

On 02/13/2024 at 10:00 PM, One-on-one Inservice conducted with Administrator by the Regional Director of Operations for weights, care plans, Quality Assurance and Performance Improvement, Notifying Physicians, Registered Dietician Recommendations, Documentation, and Administration Processes. The Regional Nurse Consultant conducted one-on-one in-services with the Director of Nursing, Dietary Manager, Assistant Director of Nursing, Medical Records Nurse, and Minimum Data Set Nurse regarding weights, care plans, Quality Assurance and Performance Improvement, Notifying Physicians, Registered Dietician Recommendations, Documentation and Administration Processes. One-on-one in-service conducted with the Dietary Manager by the Administrator regarding Communication of Dietary Recommendations, Review of Recommendations, and reporting any identified areas of concerns with Dietary Recommendations. All nurses who provided care to resident #20 for the previous 3 weeks were provided One-on-one in-services regarding reporting changes of condition to provider, documentation, and following plan of care then were provided with a post-test to confirm understanding of one-on-one in-services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 600	Continued From page 42	F 600		

As of 02/14/2024, the facility alleges compliance. All corrective action completed on 02/13/2024.

The Survey Agency (SA) validated the facility's Corrective Actions on 2/20/24:

The SA validated through record review that Resident #20 was ordered an anti-emetic for nausea/vomiting.

The SA validated through interview and record review that in-services were conducted for Abuse and neglect, documentation, provider notification, and change of condition. No staff can return to work until they have received in-services.

The SA validated through record review that all residents were interviewed and screened for symptoms of nausea and vomiting and the physician was notified of the findings with physician orders if appropriate.

The SA validated through record review and staff interview that all residents were audited for weight loss and the Medical Director was updated. All nutrition care plans were audited and updated with dietary recommendations.

The SA validated through record review that all residents with a Brief Interview for Mental Status (BIM's) of 10 or higher were interviewed to ensure feeling safe in their environment and free from health concerns.

The SA validated through record review that all Registered Dietician (RD) recommendations were audited and addressed with the provider as appropriate.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 600	Continued From page 43 The SA validated the Medical Director reviewed the resident with weight loss and performed medication review. The SA validated through staff interview and record review on 2/20/24 that an Emergency Quality Assurance and Performance Improvement (QAPI) meeting was conducted on 2/13/24 with all members in attendance. The SA validated through record review and staff interview that one-on-one in-services were conducted on weights, care plans, Quality Assurance and Performance Improvement (QAPI), notifying physicians, reporting changes, Registered Dietician Recommendations, Documentation, and Administrative Processes. No staff can return to work until they have received in-services. The SA validated on 02/20/24 that all corrective actions were completed on 2/13/24 and the IJ (Immediate Jeopardy) was removed as of 2/14/24.	F 600		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).	F 604		3/19/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 604	Continued From page 44 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, staff and family interview, record review, and facility policy review, the facility failed to identify a bed rail as a physical restraint and restricted a resident's freedom of movement for one (1) of 28 sampled residents. Resident #15 Findings Include: Record review of the facility policy titled "Physical Restraints" dated 4/23/12 revealed "Policy: It is the policy of this facility that residents have the right to be free of physical restraints not required to treat the resident's medical symptoms. Physical restraints are not to be used for the convenience of the staff or as punishment of the resident. Physical restraints or safety devices are	F 604	1. On 2/12/24, the bed rails were removed from Resident #15s bed by the Maintenance Director. 2. The alleged deficient practice has the potential to affect all residents with side rails. 3. Starting 02/27/2024 and completed by 03/18/2024 by Director of Nurses, licensed staff will be in-serviced on ensuring residents are free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the residents medical symptoms. Starting 02/27/2024 and completed by 03/18/2024 by Director	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 604	Continued From page 45 only used to enable and/or promote functional independence of the resident after consultation with a physical or occupational therapist, upon order of physician, and discussion with the resident's responsible party ..." A telephone interview on 02/12/24 at 09:40 AM, with a family member of Resident #15 revealed that the facility had not contacted her regarding the application of bed rails. An observation of Resident #15 on 2/12/24 at 2:30 PM, revealed the resident lying in bed with her eyes open, she was alert, but confused. Three-quarter (¾) side rails up on both sides of the bed were observed and the resident was trying to get up and scooted herself to the end of the opening of the bed rail, toward the footboard, and sat up on the end of the bed. Record review of the Order Summary Report for Resident #15 revealed an order dated 9/27/23, "1/2 (one-half) Side Rails X (times) 2 (two) as an enabler..." An interview with Licensed Practical Nurse (LPN) #1 on 2/12/24 at 2:40 PM revealed that Resident #15 had the side rails to prevent her from getting up due to falls. She confirmed that Resident #15 would not be able to lower the rails on her own and explained that the resident could get herself up and down from the bed into a wheelchair. She revealed that the resident usually scooted herself to the end of the bed, and sat between the rail opening when she wanted to get up. She stated she was unsure what the risks were associated with the bed rails. An interview and observation with the Director of	F 604	of Nurses, Licensed staff will be in-serviced that physical restraints or safety devices are only used to enable and/or promote functional independence of the resident after consultation with a physical or occupational therapist, upon order of physician, and discussion with the residents responsible party. Starting 02/27/2024 and completed by 03/18/2024 by Director of Nurses, Licensed staff will be in-serviced on completing a signed consent from the family, a bed rail assessment, and a physicians order for the applied bed rails must be completed prior to applying side rails. Side rail evaluation form was modified on 3/12/24 to include a signature line for informed consent. Starting 02/27/2024, the Administrator and Director of Nurses reviewed siderail use and performed siderails evaluations for all residents, consents obtained for all applicable residents. 4. Starting 02/27/2024, The Director of Nurses (DON) will conduct walking rounds on five residents with side rails weekly X 4 weeks, bi-weekly X 4 weeks and monthly x 2 months. Director of Nursing will report results of the audit to Quality Assurance Performance Improvement Committee (QAPI) monthly, starting 03/19/2024, for 3 months and as needed for review/revision.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 604	Continued From page 46 Nursing (DON) on 2/12/24 at 2:50 PM, revealed she was unsure why Resident #15 had the three-quarter (3/4) bed rails. She confirmed that the bed rails kept the resident from getting up on her own and were a barrier for her safely getting up. The DON explained the resident could possibly crawl over the top of the rails or become entrapped. She stated she had no idea how long the rails had been on the bed, and the facility had not performed a restraint assessment that would indicate a need for them. The DON explained that to her knowledge, a bed rail consent had not been signed by the family. An interview with the Regional Nurse Consultant (RNC) on 2/14/24 at 9:02 AM, revealed that after searching, she could not locate a signed consent by the family, a bed rail assessment, or a physician's order for the applied bed rails. Record review of the Quarterly Evaluation for Resident #15 dated 9/05/23 revealed, "Summary Findings... 2. Type of rail in use: Half rail 3. Rails in use: Bilateral ... 5. Bed rails are indicated and serve as an enabler to promote independence: yes..." Record review of the "Admission Record" for Resident #15 revealed the facility admitted Resident #15 on 9/02/23 with diagnoses that included Unspecified dementia, Other seizures and Repeated falls.	F 604		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.	F 641		3/19/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 641	Continued From page 47 This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review, and facility policy review the facility failed to accurately complete "Section N" of the Minimum Data Set (MDS) assessment for a Resident, as evidenced by incorrectly coding anticoagulant medication usage during the 7-day observation look-back period for one (1) of four (4) residents sampled for anticoagulant use. Resident # 23 Findings include: Record review of the facility policy titled, "Resident Assessment" dated June 1, 2000, revealed, "It is the policy of this facility that a comprehensive review of a resident's needs be made within fourteen (14) days of the resident's admission. Procedure ... 3 ...Information derived from the comprehensive assessment enables the staff to plan care that allows the resident to reach his/her highest practicable level of functioning and may include: ...m. Drug therapy (all prescription and over-the-counter medication taken by the resident, including dosage and frequency of administration) ..." Record review of the MDS with an Assessment Reference Date (ARD) of Jan 25, 2024, revealed under section N, Resident #23 received seven (7) days of anticoagulant medication for the observation look back period of 1/19/24 through 1/25/24. Record review of the Electronic Medication Administration Record (eMAR) for the MDS 7-day observation look-back period for anticoagulant medication revealed Resident #23 did not receive anticoagulant medication between 1/19/24 and	F 641	1. On 02/13/2024, Minimum Data Set assessment was modified by the Minimum Data Set Nurse. All residents assessments were audited for correct accuracy regarding anticoagulant use and modified if errors were found. 2. This alleged deficient practice has the potential to affect all residents. 3. On 02/27/2024, the Administrator conducted one on one in-service with the Minimum Data Set Nurse for accuracy of coding Minimum Data Set assessments. 4. Starting 02/27/2024, the Director of Nurses will audit all assessments for accuracy of coding anticoagulants weekly times 4 then bi- weekly times 4 weeks, then monthly for times 2 months. The Director of Nursing will take immediate corrective action is noted. The Director of Nursing will present audit findings to Quality Assurance and Performance Improvement committee monthly, starting 03/19/2024, for 3 months and as needed for review and revision	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 641	Continued From page 48 1/25/24. An interview with the MDS Coordinator on 02/13/24 at 11:25 AM, confirmed Resident #23 was coded on the 7-day look-back period for receiving an anticoagulant medication. She revealed that Resident #23 received an antibiotic medication instead of an anticoagulant and the 7 days of anticoagulant medication was coded in error. Record review of the Admission Record for Resident #23 revealed he was admitted to the facility on 01/19/2024 with diagnoses that included Pneumonia, Chronic obstructive pulmonary disease, and Malignant neoplasm of bladder.	F 641		
F 656 SS=J	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights	F 656		3/19/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 656	Continued From page 49 under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, record review and facility policy review, the facility failed to implement a comprehensive care plan for five (5) of eighteen sampled residents as evidenced by: Resident #13, #15, #20, #26, and #54 1) failed to implement the nutritional care plan for Resident #13 which resulted in a significant weight loss which placed the resident at risk for dehydration, malnutrition, skin breakdown and	F 656	1. On 02/11/2024, antiemetic medication was ordered for resident #20. On 2/13/2024, In-service for Abuse and Neglect for staff began by the Assistant Director of Nursing. On 02/13/2024, Social Services and Medical Records Nurse interviewed all residents for nausea and vomiting and reported to provider with orders provided as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 656	Continued From page 50 placed the resident and all other residents residing in the facility at risk for serious harm, serious injury, serious impairment, and possibly death. 2) failed to implement a pain and nutritional care plan for Resident #20 which resulted in the resident experiencing prolonged nausea, vomiting, and an infrequent passage of stool (constipation), significant weight loss, with a potential outcome for fecal impaction, bowel obstruction (blockage), dehydration, malnutrition, skin breakdown and placed the resident and all other residents residing in the facility at risk for serious harm, serious injury, serious impairment, and possibly death. Findings that did not rise to the level of Immediate Jeopardy: 3) failed to implement a care plan for personal hygiene for Resident #26, and Resident #54 as evidenced by long nails with a brown/black substance underneath. 4) failed to implement a care plan for bedrails and oxygen for Resident #15. The State Agency (SA) identified an Immediate Jeopardy (IJ) that began on 11/02/23 when the facility failed to recognize, evaluate, and address Resident #13's nutritional needs, which resulted in an unintended significant weight loss of 6.92% (percent) in one (1) month, which further led to a significant weight loss of 17.52% (percent) in four (4) months. The facility's failure to consult a Registered Dietician (RD), notify the attending physician of a significant change in condition, and act upon the residents' weight loss, placed the	F 656	On 02/13/2024, the Director of Nursing notified providers of residents with complaints of nausea and vomiting. On 02/13/2024, all residents were audited for weight loss by the Director of Nursing, Regional Nurse Consultant, and Minimum Data Set Nurse. On 02/13/2024, Providers for all residents with weight loss were notified by the Director of Nursing, Assistant Director of Nursing, and Medical Records Nurse. On 02/13/2024, a medication review for all residents with weight loss was conducted by the medical director. On 02/13/2024, Dietary Manager and Minimum Data Set Nurse audited all Registered Dietician Recommendations for the last 90 days were reviewed with provider and new orders and implemented. On 02/13/2024, all nutrition care plans were audited by the Minimum Data Set Nurse and updated to reflect dietary recommendations. Ad Hoc Quality Assurance and Performance Improvement meeting was held on 02/13/2024. On 02/13/2024, One-on-One in-services with the Director of Nursing, Dietary Manager, Assistant Director of Nursing, Medical Records Nurse, and Minimum Data Set Nurse regarding	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 656	Continued From page 51 resident, and all other residents residing in the facility at risk for serious negative outcomes. The IJ existed at: 42 CFR §483.21(b)(1) Comprehensive Care Plans - F656 - Scope/Severity "J" The facility Administrator was notified of the IJ on 2/13/24 at 4:30 PM and provided the IJ Template. The facility provided an acceptable Removal Plan on 2/14/24, in which they alleged all corrective actions to remove the IJ were completed on 2/13/24 and the IJ removed on 2/14/24. The SA validated the Removal Plan on 2/20/24 and determined the IJ was removed on 2/14/24. Therefore, the scope and severity for 42 CFR §483.21(b)(1) Comprehensive Care Plans - F656 was lowered from a "J" to a "D" while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings Include: Review of the facility policy titled "Care Plan - Comprehensive" undated, revealed, "Policy Statement: It is the policy of this facility to develop comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and psychological needs...Procedure: 1. An interdisciplinary team, in coordination with the resident and his/her family or representative, develops and maintains a comprehensive care plan for each resident. 2. The comprehensive	F 656	weights, care plans, notifying physician, Quality Assurance and Performance Improvement meetings, Registered Dietitian Recommendations, Documentation, and Administration were conducted by the Regional Nurse Consultant. On 02/13/2024, the Regional Director of Operations conducted and One-on-One in-service with the Administrator regarding weights, care plans, notifying physician, Quality Assurance and Performance Improvement meetings, Registered Dietitian Recommendations, Documentation, and Administration. On 02/13/2024, the nurses who provided care to resident # 20 for previous three weeks were provided one-on-one for reporting changes of condition to provider, documentation, and following plan of care and provided posttest to confirm understanding by the Director of Nursing and Assistant Director of Nursing. On 02/14/2024, resident #20 was ordered appetite stimulant. On 02/14/2024, Resident #20 was admitted to hospice services. On 2/15/2024, resident #13 was ordered fortified cereal and fortified mashed potatoes. On 02/13/2024, residents #26 and #54 were provided nail care by Registered Nurse Supervisor. On 03/04/2024, all oxygen and bed rails care plans were audited by the Minimum Data Set Nurse and corrections	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 656	Continued From page 52 care plan had been designated to: a. Incorporate identified focus areas b. Incorporate risk factors associated with identified problems c. Build on the resident's strengths d. Reflect treatment goals and objectives in measurable outcomes that incorporate the resident's personal and cultural preferences and wishes e. Identify the professional services that are responsible for each element of care f. Enhance the optional functioning of the resident by focusing of rehabilitative programs and resources as needed ..." Resident #13 Cross reference F580, F600, F692 During an interview on 2/13/24 at 11:05 AM, Resident #13 stated she had lost weight while in the facility. She revealed there were times she did not eat well and she did not receive supplements. Record review of Resident #13's Comprehensive Care Plan dated 12/19/23 revealed a care plan for potential nutritional problems with interventions including, "Observe/record/report to MD (medical doctor) PRN (as needed) signs/symptoms of malnutrition: emaciation (Cachexia), muscle wasting, significant weight loss - three (3) pounds in one week, greater than 5% in one month, and greater than 7.5% in 3 months." At 11:40 AM on 2/14/24, during an interview the Director of Nursing (DON) revealed Resident #13 had a significant weight loss which was not reported to the physician for interventions, therefore, her weight continued to decrease. This led to a 6.92% weight loss during her first month at the facility and to a 17.5% weight loss during	F 656	made as needed. On 02/12/2024, Resident #11 was offered to be shaved by Certified Nursing Aide and agreed. 2. All residents in the facility have the potential to be affected by the alleged negligent practices. 3. On 02/13/2024 the Minimum Data Set Nurse (MDS), the Director of Nurses(DON), and licensed nurses were educated by Regional Nurse Consultant regarding comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident□s medical, nursing, mental, psychosocial needs. On 03/04/2024 the Minimum Data Set Nurse reviewed all care plans to ensure that nail care, diabetic nail care, pain, personal hygiene, bed rails and oxygen are properly reflected on the care plan and completed required revisions. Beginning on 02/13/2024 the MDS nurse will review physician orders five times per week to ensure that all plans of care are updated. Beginning on 02/13/2024 the Director of Nurses will review five times per week, all progress notes, new admissions, any resident with a change of condition to ensure appropriate actions were taken.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 656	Continued From page 53 her first four months at the facility. She confirmed the resident's care plan for nutritional problems included an intervention to report to the physician as needed any signs or symptoms of malnutrition or significant weight loss and this was not followed. She confirmed the facility failed to follow care plan. At 8:45 AM on 2/15/24, an interview with the facility's Regional Nurse Consultant , revealed the physician was not consulted concerning Resident #13 significant weight loss so therefore, no interventions were initiated and weight continued to decline. She confirmed the care plan informed staff to notify the physician for concerns with nutrition such as weight loss and this was not followed. An interview with the Minimum Data Set (MDS) Registered Nurse (RN) on I2/14/24 at 5:30 PM, revealed the purpose of the care plan was for the staff to know the resident's needs and preferences and how to care for the resident and this resident's care plan for nutritional needs was not followed. Record review of Resident #13's Admission Record revealed she was admitted to the facility on 10/2/23. Diagnoses included Stevens-Johnson Syndrome, Non-pressure Ulcers, Anxiety Disorder, Major Depressive Disorder. Record review of Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 12/12/23 revealed a Brief Interview for Mental Status (BIMS) score of 12 which indicated the resident was moderately cognitively impaired.	F 656	4. Starting 02/13/2024, The MDS nurse will audit all new orders, changes of conditions, and new admissions for person-centered care plans with measurable goals, five times a week for four weeks, then two times a week for four weeks, and subsequently monthly. The MDS nurse will take immediate corrective action as needed. The MDS nurse will report findings to the Quality Assurance and Performance Improvement committee meeting monthly for review and/or revision of the plan. Starting 02/13/2024, the Director of Nursing (DON) will review progress notes for changes in resident condition or updates five times per week for four weeks, then two times a week for four weeks, and subsequently monthly. The DON will take immediate corrective action as needed. The DON will report findings to the Quality Assurance and Performance Improvement committee meeting monthly, starting 03/19/2024, for 6 months for review and/or revision of the plan then as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 656	Continued From page 54	F 656		

Resident #20 Cross reference F580, F600, F684, F692

Record review of Resident #20's Pain Care Plan revealed under, "Interventions/Tasks: ... Observe/document for side effects of pain medication. Observe for constipation; ... nausea; vomiting; ... Report occurrences to the physician."

Record review of Resident #20's "Order Summary Report" revealed an order dated 1/02/24, "Norco Oral Tablet 7.5 -325 MG (milligrams) (Hydrocodone-Acetaminophen) Give 7.5 mg (milligrams) by mouth every 6 (six) hours related to Pain ..."

Record review of Resident #20's "Order Summary Report" revealed an order dated 12/13/23, "Tramadol HCL (Hydrochloride) Tablet 50 MG (milligrams) Give 1 tablet by mouth every 12 (twelve) hours as needed for pain." Also revealed an order dated 12/13/23, "Tramadol HCL (Hydrochloride)Tablet 50 MG (milligrams) Give 2 (two) tablets by mouth every 12 (twelve) hours as needed for pain ..."

At 3:19 PM on 2/11/24, an observation and interview with Resident #20, revealed her lying in a fetal position at the foot of the bed with small garbage can was located on the floor close beside the resident. She stated she was sick to her stomach and had a washcloth in her hand and was wiping her face.

At 8:35 AM on 2/12/24, an interview with Certified Nurse Aide (CNA) #2 revealed Resident #20 had been nauseated, dry heaving, and vomiting for the three (3) weeks since she had been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 656	Continued From page 55	F 656		

employed at the facility. She revealed that she had reported it to the medication nurse every day that she worked.

At 5:36 PM on 2/13/24, an interview with the Director of Nursing, confirmed that the facility did not have a monitoring tool in place for Resident #20 to monitor for the common side effects of an opioid pain medication such as constipation, nausea, and vomiting. The DON confirmed that the resident's care plan was not being followed because the physician had not been notified of the nausea and vomiting.

Record review of Resident #20's Nutritional Care Plan revealed, "Focus: I have potential nutritional problem...Interventions/Tasks: 01/04/24 - discussed weight loss in idt (interdisciplinary) meeting, nsg (nursing) to notify md (Medical Doctor) of weight change and await instruction to poc (plan of care) ... 01/05/24 - RD (Registered Dietician) consult ... Resident may benefit from an appetite stimulant ... Add fortified pudding BID (twice daily) at lunch and dinner ... 02/10/24 - RD review ... Resident may benefit from appetite stimulant ... If po (by mouth) intake and wt (weight) status does not improve, Resident may benefit from an alternate means of nutrition support. Will continue to monitor po (by mouth) intake, wt (weight) trends, labs and skin ..."

Record review of Resident #20's weights revealed a significant weight loss of 13.9% (percent) in one (1) month, 21.6% (percent) in three (3) months, and 26.2% (percent) in six (6) months.

Record review of the "Order Summary Report" for Resident #20 revealed there was not a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 656	Continued From page 56	F 656		

physician's order for fortified pudding at lunch and supper or a medication to stimulate appetite per Registered Dietician (RD) recommendations.

An interview with the Minimum Data Set (MDS) Nurse on 2/14/24 at 5:23 PM revealed that she developed the Nutritional Care Plan for Resident #20 by reading the Registered Dietician (RD) progress notes in the Electronic Medical Record (EMR) and adding the recommendations to the Care Plan. She revealed that she was aware that the resident did not have a physician's order for the fortified pudding or an appetite stimulant, but she thought the RD recommendation should be listed on the care plan. She stated, "I can't say if the nutritional care plan was being followed because the weight loss was being addressed, even though the RD recommendations were not implemented." She revealed the purpose of the care plan was to give staff a guide to follow to know how to care for a resident.

Record review of the "Transfer/Discharge Report" revealed the facility admitted Resident #20 on 1/24/22 with medical diagnoses that included Alzheimer's disease, rheumatoid arthritis, primary open-angled glaucoma, and wedge compression fracture of T 11-T 12 vertebra, subsequent encounter for fracture with delayed healing.

Record review of Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 01/10/24 revealed a Brief Interview for Mental Status (BIMS) score of 03 which indicated the resident had severe cognitive impairment. Prior MDS's dated 09/18/23 revealed a BIMS of 11, MDS dated 12/11/23 revealed a BIMS of 9.

Findings that did not rise to the level of IJ:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 656	Continued From page 57	F 656		

Resident #54

Record review of Resident #54's Comprehensive Care Plan revealed the resident had an Activities of Daily Living self-care performance deficit. One intervention listed was personal hygiene - partial moderate assist.

An interview with and observation of Resident #54 on 02/12/24 at 9:30 AM, revealed his fingernails were noted to be approximately 1/2 inch from nail bed with dark brown/black substance noted under each nail. He stated he prefers his nails to be kept short and he would like for them to be trimmed today.

An interview on 2/12/24 at 3:20 PM, the Assistant Director of Nursing (ADON) confirmed Resident #54 had multiple scratch marks on abdomen and arms and nails were long and dirty with a substance under nails that appeared to be old dried blood. She confirmed the resident's nails should be kept clean and trimmed to the length the resident preferred and since he preferred his nails short, the staff needed to assist him to ensure this was done. She confirmed the facility failed to provide the resident's Activities of Daily Living (ADL) care for his nail care needs. She confirmed that nail care was part of the resident's personal hygiene care plan and this was not followed.

An interview with the Director of Nursing (DON) on 2/12/24 at 4:55 PM, revealed the facility failed to ensure adequate Activity of Daily Living (ADL) nail care for a dependent resident was done. She confirmed the care plan was to inform staff of the needs and preferences for each resident and this

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 656	Continued From page 58	F 656		

part of Resident #54's personal hygiene care plan was not followed.

During an interview on I2/14/24 at 5:30 PM, the Minimum Data Set (MDS) Registered Nurse (RN) confirmed the purpose of the care plan was for the staff to know the resident's needs and preferences and how to take care of the resident and this resident's care plan for personal hygiene assistance was not followed.

Record review of Resident #54's Admission Record revealed the resident was admitted to the facility on 11/9/23. Diagnoses included Muscle Weakness and Lack of Coordination.

Record review of Resident #54's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 1/5/24, Section GG revealed for personal hygiene, Resident #54 required partial/moderate assistance.
Section C revealed a Brief Interview for Mental Status (BIMS) score of 11 which indicated the resident had moderate cognitive impairment.

Resident #26

Record review revealed an ADL care plan in place for Resident #26 with a focus on ADL self-care performance deficit related to Parkinson's disease with an intervention under Bathing/showering to check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse.

During an observation and interview on 02/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 656	Continued From page 59	F 656		

at 5:55 PM, Resident #26's fingernails on both hands were approximately one-half (1/2) inch long and jagged with a brown substance underneath the nails. Resident #26 revealed he would like his nails to be cut because they are too long.

An interview with Licensed Practical Nurse (LPN) #2 on 02/12/24 at 2:55 PM, revealed Resident #26 is a diabetic and his nails must be cut by a registered nurse, the LPNs are not allowed to cut diabetic nails. She confirmed while reviewing Resident #26's care plan that Resident #26 did not have a care plan for his nails to be cut only by a registered nurse.

During an interview on 02/12/24 at 3:10 PM, the DON revealed the registered nurses are responsible for doing diabetic nail care. She confirmed that Resident #26 did not have on his ADL or diabetic care plan for the registered nurses to cut his nails and revealed his care plan was not developed to specify the nail care for a diabetic. She confirmed he did not have an order for his fingernails to be cut by an RN and therefore it didn't show up on the Treatment Administration Record (TAR) for the registered nurse to cut his nails.

Record review of Resident #26's Admission Record revealed the resident was admitted to the facility on 09/13/2023 with medical diagnoses that included Parkinsonism, Chronic obstructive pulmonary disease, and Type 2 Diabetes Mellitus with hyperglycemia.

Record review of Resident #26's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of Dec 19, 2023, revealed a Brief Interview

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 656	Continued From page 60	F 656		

for Mental Status (BIMS) score of 03, which indicated the resident is severely cognitively impaired.

Resident #15

Record review of the Care Plan, undated, for Resident #15 revealed, "I have an ADL self-care performance deficit ... Interventions: ...BED MOBILITY: The resident uses half rails x (times) 2 (two) to improve bed mobility ..."

On 2/12/24 at 2:30 PM, an observation of Resident #15 revealed the resident lying in bed with her eyes open. She was alert/verbal and confused. Three -quarter (¾) side rails were up on both sides.

Record review of the Quarterly Evaluation for Resident #15 dated 9/05/23 revealed, "Summary Findings ... 2. Type of rail in use: Half rail 3. Rails in use: Bilateral... 5. Bed rails are indicated and serve as an enabler to promote independence: yes..."

On 2/12/24 at 2:50 PM, an interview and observation with the Director of Nursing (DON) , confirmed Resident #15 had three-quarter (3/4) rails. She stated she had no idea how long the rails had been on the bed.

An interview with the Minimum Data Set (MDS) Nurse on 2/14/24 at 5:19 PM, revealed that the purpose of the Care Plan was for the staff to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 656	Continued From page 61	F 656		

know how to care for a resident. She confirmed that Resident #15 did not have a care plan for the applied bed rails.

Record review of the "Admission Record" for Resident #15 revealed the facility admitted Resident #15 on 9/02/23 with diagnoses that included Unspecified dementia, Other seizures and Repeated falls.

The facility submitted the following removal plan:

On 02/13/2024 at 4:30 PM, the Mississippi State Department of Health (MSDH) state survey team notified the Administrator of an Immediate Jeopardy for failing to ensure processes were in place to review and implement Registered Dietician (RD) recommendations, notify the physician of weight loss, and implement interventions to address weight loss for Resident #20, who had lost 40.5 lbs in the last six months. Resident #20 also had nausea and vomiting and was not eating or drinking adequately for the last three weeks and the facility had failed to notify the physician of the significant change. The facility failed to follow care plan interventions to identify weight loss and address weight loss for Resident #20. The facility failed to have an effective Quality Assurance and Performance Improvement (QAPI) meeting to ensure all recommendations from the Registered Dietician were addressed in a prompt manner. Review of facility processes revealed that the recommendations from the registered dietician was being sent to the Dietary Manager via email and the emails were not received and not presented to the interdisciplinary team and reviewed by the provider and implemented. Interview with staff indicates that resident has had poor appetite since January,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 656	Continued From page 62	F 656		

and it was not documented in the medical record.

On 02/11/2024 at 6:27 PM, the facility nurse notified the provider and obtained orders for anti-emetic.

On 2/12/2024 at 9:27 am, the facility attempted to transfer resident to the emergency room for evaluation and treatment as indicated. The Responsible Party refused for resident to be sent to the emergency room on this date. The facility obtained a physician's order for hospice services.

On 02/13/2024 5:00 PM, In-services began on Abuse and Neglect for all staff by the Assistant Director of Nursing. All staff will be trained prior to returning to work. In-services began by Assistant Director of Nursing on Documentation, Provider Notification, and Change of Condition. All staff will be trained prior to returning to work.

On 02/13/2024 at 5:15 PM, Social Services and Medical Records Nurse interviewed all residents regarding Nausea and Vomiting to ensure all significant changes of conditions were reported to the providers. It was noted upon interview that nine (9) residents reported recent complaints of nausea and vomiting, one (1) resident noted to have yellow discharge from mouth and nose, 1 resident was unable to recall when nausea or vomiting occurred with no staff being knowledgeable of nausea or vomiting, two (2) residents reported nausea or vomiting after eating, 2 residents reported not having appetite or eating, 1 resident reported nausea but did not report to nurse, 2 residents reported nausea and medications received.

On 02/13/2024 at 5:30 PM, all residents were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 656	Continued From page 63	F 656		

audited for weight loss by the Director of Nursing, Regional Nurse Consultant, and Minimum Data Set Nurse. Results of weight loss audit were reviewed by the medical director (15 unplanned weight losses, 1 planned) and new orders and diagnoses were provided by the medical director. All nutrition care plans audited by Minimum Data Set Nurse on 02/13/2024 with 5 residents whose registered dieticians' recommendations were not on care plans, dietary recommendations reviewed with providers and orders received per providers.

On 02/13/2024 at 6:05 PM, the Director of Nursing notified the physician of all 9 residents, notified the Institutional Specialized Needs Plan (ISNP) nurse practitioner of all residents (4) and hospice of all residents (1) with Nausea and Vomiting with new orders received from provider. 1 resident reviewed with new orders for chest x-ray due to cough, congestion, and yellow discharge from mouth and nose, 2 residents were ordered medications for reflux, 1 resident noted to be receiving antibiotics and has orders in place for anti-emetic medications, 1 resident reported abdominal pain and MD was notified and seen resident on 02/12/2024 with new orders for stool softener, 1 resident noted to have diarrhea and has been antibiotics new orders received for Zofran and anti-diarrheal, 1 resident noted to have weight loss and nausea and vomiting new orders received on 2/11/2024 to start Zofran and start peri-actin the family was not agreeable to start peri-actin and wanted to wait to speak to hospice on 02/14/2024, 2 residents did not report nausea to nurses at time of occurrence.

On 02/13/2024 at 6:59 PM, Social Services and Medical Records nurse interviewed residents with BIMS 10 or higher to ensure feeling of safe and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 656	Continued From page 64	F 656		

are free of health concerns, no health or safety concern during interviews.

On 02/13/2024 at 8:30 PM, all Registered Dietician recommendations for last 90 days audited by Dietary Manager and Minimum Data Set Nurse with 5 residents whose registered dietician recommendations were not addressed. All Dietary recommendations reviewed with the Medical Director (5) and subsequent providers as appropriate Hospice (2 residents who have been on hospice services prior to survey entrance) and Institutional Special Needs Program nurse practitioner (1), new orders received from providers as appropriate.

On 02/13/2024 at 8:40 PM, All nutrition care plans audited by Minimum Data Set Nurse with 5 residents whose registered dieticians' recommendations were not on care plans, dietary recommendations reviewed with providers and orders received per providers and care plans updated.

On 02/13/2024 at 9:00 PM, all residents noted with weight loss were reviewed with the Medical Director, the Medical Director performed medication review on all residents with weight loss.

Ad Hoc QAPI was held on 02/13/2024 at 10:15 PM with the Medical Director via phone, Administrator, Director of Nursing, Social Services, Minimum Data Set Nurse, Life Connections Coordinator, Regional Nurse Consultant, Regional Director of Operations, Assistant Director of Nursing, Registered Nurse Supervisor, Dietary Manager, and Medical Records Nurse. The Minimum Data Set Nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 656	Continued From page 65	F 656		

has been designated as the Quality Assurance Nurse with responsibility reviewing all audits, Performance Improvement Plans, Quality Measures, and actively participating in the Quality Assurance and Performance Improvement meetings. All areas of deficiencies were reviewed in Ad-Hoc Quality Assurance and Performance Improvement meeting. Medical Records nurse or Assistant Director of Nursing will be responsible for receiving Registered Dietician recommendations, reviewing with providers, entering orders, and progress notes. New processes for Medical Director to review facility weight losses each week on visit, Registered Dietitian recommendations to be reviewed weekly with the Interdisciplinary Team and the Medical Director by Friday, in the event Registered Dietician recommendations are not received, the medical director will be notified. The Dietary Manager will review the weight and vital sign exception report and present findings in the clinical meeting. The Director of Nursing will review weights and registered dietician recommendations. The Director of Nursing will review progress notes daily. The administrator will review the audit findings weekly. All results will be reviewed in Quality Assurance and Performance Improvement meetings.

On 02/13/2024 at 10:00 PM, One-on-one Inservice conducted with Administrator by the Regional Director of Operations for weights, care plans, Quality Assurance and Performance Improvement, Notifying Physicians, Registered Dietician Recommendations, Documentation, and Administration Processes. The Regional Nurse Consultant conducted one-on-one in-services with the Director of Nursing, Dietary Manager, Assistant Director of Nursing, Medical Records

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 656	Continued From page 66	F 656		

Nurse, and Minimum Data Set Nurse regarding weights, care plans, Quality Assurance and Performance Improvement, Notifying Physicians, Registered Dietician Recommendations, Documentation and Administration Processes. One-on-one in-service conducted with the Dietary Manager by the Administrator regarding Communication of Dietary Recommendations, Review of Recommendations, and reporting any identified areas of concerns with Dietary Recommendations. All nurses who provided care to resident #20 for the previous 3 weeks were provided One-on-one in-services regarding reporting changes of condition to provider, documentation, and following plan of care then were provided with a post-test to confirm understanding of one-on-one in-services.

As of 02/14/2024, the facility alleges compliance and all corrective actions were completed on 02/13/2024.

The Survey Agency (SA) validated the facility's Corrective Actions on 2/20/24:

The SA validated through record review that Resident #20 was ordered an anti-emetic for nausea/vomiting.

The SA validated through interview and record review that in-services were conducted for Abuse and neglect, documentation, provider notification, and change of condition. No staff can return to work until they have received in-services.

The SA validated through record review that all residents were interviewed and screened for symptoms of nausea and vomiting and the physician was notified of the findings with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 656	Continued From page 67 physician orders if appropriate. The SA validated through record review and staff interview that all residents were audited for weight loss and the Medical Director was updated. All nutrition care plans were audited and updated with dietary recommendations. The SA validated through record review that all residents with a Brief Interview for Mental Status (BIM's) of 10 or higher were interviewed to ensure feeling safe in their environment and free from health concerns. The SA validated through record review that all Registered Dietician (RD) recommendations were audited and addressed with the provider as appropriate. The SA validated the Medical Director reviewed the resident with weight loss and performed medication review. The SA validated through staff interview and record review on 2/20/24 that an Emergency Quality Assurance and Performance Improvement (QAPI) meeting was conducted on 2/13/24 with all members in attendance. The SA validated through record review and staff interview that one-on-one in-services were conducted on weights, care plans, Quality Assurance and Performance Improvement (QAPI), notifying physicians, reporting changes, Registered Dietician Recommendations, Documentation, and Administrative Processes. No staff can return to work until they have received in-services. The SA validated that all corrective actions were	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 656	Continued From page 68 completed on 2/13/24 and the IJ was removed as of 2/14/24.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure delivery of care met professional standards of nursing practice for a resident receiving continuous oxygen for one (1) of five (5) residents reviewed with continuous oxygen. Resident #15 Findings Include: Record review of the facility policy titled "Change in a Resident's Condition or Status" with a review date of 7/24/23 revealed, "Policy Statement: Our facility notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status...Policy interpretation and Implementation: 1. The nurse will notify the resident's attending physician or physician on call when there has been a (an):... f. refusal of treatment or medications two (2) or more consecutive times) ..." Record review of the facility policy titled "Oxygen Administration" dated 8/25/14, revealed " ... Preparation: 1. Verify that there is a physician's	F 658	1. On 02/12/2024, the resident was encouraged to apply oxygen. On 02/12/24 the provider was notified by Assistant Director of Nurses of resident□s refusals to wear oxygen with orders to discontinue. 2. The alleged deficient practice has the potential to affect all residents on oxygen. 3. On 03/04/2024 licensed nurses in-serviced by Director of Nursing on ensuring physician orders are accurately transcribed and documented including notifying provider of refusals to meet professional standards of quality. On 02/13/2024 the Regional Nurse Consultant (RNC), in-serviced DON and ADON on ensuring physician orders are accurately transcribed and documented including notifying provider of refusals to meet professional standards of quality. 4. Starting 03/08/2024, the director of nursing will make weekly walking rounds	3/19/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 658	Continued From page 69 order for this procedure... Documentation: After completing the oxygen setup or adjustment, the following information should be recorded in the resident's medical record: ... 7. How the resident tolerated the procedure. 8. If the resident refused the procedure, the reason(s) why and the intervention taken. Reporting: 1. Notify the supervisor if the resident refuses the procedure ..." On 2/11/24 at 4:39 PM, in an observation of Resident #15, revealed the resident lying in bed with her eyes closed. She was unable to arouse to verbal stimuli. The resident's oxygen concentrator was observed by the bedside, with the cannula laying over the concentrator. On 2/12/24 at 2:35 PM, in an observation of Resident #15, revealed the resident lying in bed. The resident was alert/verbal and confused. The oxygen cannula was observed laying over the oxygen concentrator at the bedside. Record review of the Order Summary Report for Resident #15 revealed an order dated 1/12/24, "O2 (oxygen) on continuously at 2ls (two liters) bnc. (by nasal cannula) every shift..." On 2/12/24 at 2:43 PM in an observation and interview with Licensed Practical Nurse (LPN) #1 confirmed that Resident #15 had not been wearing oxygen. LPN # 1 revealed the resident had been refusing to wear the oxygen for a while. She revealed that she had not notified the physician of the resident's refusal. She revealed that she should have documented that the resident refused the oxygen on the Medication Administration Record (MAR), instead she documented it as administered, which indicated	F 658	of all residents with oxygen times 4 weeks, then bi-weekly times 4 weeks, then monthly times 2 months to ensure residents are receiving oxygen as ordered and that documentation of residents□ use of oxygen is correct. The Director of Nursing will take immediate corrective action if needed. The Director of Nursing will present the audit findings to Quality Assurance and Performance Improvement Committee monthly starting, 03/19/2024 for 6 months then as needed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 658	Continued From page 70 the resident was wearing it. LPN #1 stated she was unsure how long a resident must refuse a medication before the physician was contacted to notify. On 2/12/24 at 2:57 PM, in an observation and interview with the Director of Nursing (DON) confirmed she was aware that Resident #15 had been refusing oxygen, and to her knowledge, none of the staff had reached out to the physician to make him aware. She confirmed that the Medication Administration Record (MAR) should reflect that the resident refused, and the facility should have notified the physician. Record review of the February 2024, Medication Administration Record (MAR) revealed an order dated,1/12/24 "O2 (oxygen) on continuously at 2ls (two liters) bnc (by nasal cannula) every shift" documented as administered 2/1/24 through 2/12/24 with no refusals. Record review of the "Progress Notes" for Resident #15 revealed there was not any documentation to support the refusal of oxygen. Record review of the "Admission Record" for Resident #15 revealed the facility admitted Resident #15 on 9/02/23 with diagnoses that included Unspecified dementia, Other seizures and Repeated falls.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;	F 677		3/19/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 677	Continued From page 71 This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews, record review, and facility policy review, the facility failed to ensure residents who required assistance with Activities of Daily Living (ADLs) were assisted with personal hygiene as evidenced by long, jagged nails with brown substance underneath nails and unshaven facial hair for three (3) of eighteen residents sampled. Resident #11, Resident #26, and Resident #54 Findings include: Record review of the facility policy titled "Shaving The Resident" dated 8/25/14, revealed "Purpose: The purpose of this procedure is to promote cleanliness and to provide skin care ..." Record review of facility policy titled, "A.M. Care (Day Tour of Duty) with a revision date of August 25, 2014 revealed "Purpose: 1. To refresh the resident. 2. To provide cleanliness, comfort and neatness .... Equipment: See specific procedures for: Care of nails. ...Documentation 1. Date, time, care provided ... 4. Signature, title and date..." Resident #11 An observation and interview with Resident #11 on 2/11/24 at 3:26 PM, revealed the resident was up in his chair in the hallway. The resident was observed with one-eighth (1/8) inch of white facial hair. An interview with Resident #11 on 2/11/24 at 3:31 PM, revealed he would like to be shaved on his shower days that were scheduled on Tuesday, Thursday, and Saturday. He stated that he did not	F 677	1. On 02/12/2024, Resident #11 was offered to be shaved by Certified Nursing Aide and agreed. On 02/13/2024, Residents #26 and #54 were provided nail care by Registered Nurse Supervisor. 2. This alleged deficient practice has the potential to affect all residents. 3. Licensed staff in-serviced by Director of Nurses and Administrator on ADL care including nail care and shaving starting on 02/13/2024 and completed by 03/18/2024. On 02/12/2024 all nail care orders were audited by Assistant Director of Nurses to ensure that nail care was on the treatment administration record. Any residents who did not have orders in place were immediately put into place. 4. Starting 03/04/2024, the Director of Nurses will make weekly walking rounds and audit five residents a week to ensure that residents have appropriate nail care and are offered to be shaved weekly times 4 weeks, bi-weekly times 4 weeks, then monthly times 2 months. The Director of Nurses will take immediate corrective action as needed. Starting 03/04/2024, the Medical Records Nurse will audit five residents per week to ensure that orders are in place and documented on the Treatment Administration Record weekly times 4 weeks, bi-weekly times 4, and then monthly times 2 months. The Director of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 677	Continued From page 72 get shaved yesterday and explained that he was not sure why. An observation and interview of Resident #11 on 2/12/24 at 3:05 PM, with the Administrator (ADM), confirmed that the resident needed shaving. The resident explained to the ADM that he had not been shaved since last Tuesday (2/06/24). The ADM revealed that they have a shower team that worked Monday through Friday and were responsible for shaving the residents. She revealed on Saturday's, it was the assigned aide's responsibility. She revealed that shaving was expected to be done with the showers. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/29/24 revealed, under section GG, Resident #11 required partial/moderate assistance with personal hygiene. Record review of the "Admission Record" revealed the facility admitted Resident #11 on 10/05/20 with medical diagnoses that included peripheral vascular disease, acquired absence of unspecified leg above knee, gout, heart failure, and essential (primary) hypertension. Resident #26 An observation and interview on 02/11/24 at 5:55 PM, Resident #26's fingernails on both hands were approximately one-half (1/2) inch long and jagged with a brown substance underneath the nails. Resident #26 revealed he would like his nails to be cut because they are too long. An observation and interview on 02/12/24 at 2:50 PM, with Certified Nursing Assistant (CNA) #6	F 677	Nurses and Medical Records nurse will present audit findings to the Quality Assurance and Performance Improvement Committee monthly starting 03/19/2024 for 3 months then as needed for review and revision.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 677	Continued From page 73	F 677		

confirmed that Resident #26's nails were long and uneven and had a brown substance under them and needed to be cleaned and trimmed. She stated, "I'll check with the nurse to see if the resident is diabetic or not, the aides aren't allowed to do diabetic nails and I'm not sure if he is or not."

On 02/12/24 at 2:55 PM, an interview and record review with Licensed Practical Nurse (LPN) #2 revealed Resident #26 is a diabetic and his nails must be cut by a Registered Nurse (RN). She stated the LPNs are not allowed to cut diabetic nails. During a review of Resident #26's Treatment Administration Record (TAR), LPN #2 confirmed it was not listed on his TAR for the RN's to do nail care and there was no place for the nurses to document.

An interview and observation on 02/12/24 at 3:10 PM, the Director of Nurses (DON) revealed the RNs are responsible for providing diabetic nail care. She revealed it should show up on the Treatment Administration Record (TAR) and the RN would sign off that it has been done. She confirmed that Resident #26's fingernails were long and jagged with a brown substance under them, and stated, "The resident could scratch himself and cause a skin tear or infection."

Record review of Resident #26's Admission Record revealed the resident was admitted to the facility on 09/13/2023 with medical diagnoses that included Parkinsonism, Chronic obstructive pulmonary disease, and Type 2 Diabetes Mellitus with hyperglycemia.

Record review of Resident #26's MDS an ARD of 12/19/23, revealed a Brief Interview for Mental

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 677	Continued From page 74	F 677		

Status (BIMS) score of 03, which indicated the resident is severely cognitively impaired.

Resident #54

An interview and observation on 02/12/24 at 9:30 AM, revealed Resident #54's fingernails were noted to be approximately one-half (1/2) inch from the nail bed and extending over the tips of his fingers with a dark brown/black substance noted under each nail. Resident #54 stated he preferred his nails to be kept short and he would like for them to be trimmed today.

During an observation and interview with Licensed Practical Nurse (LPN) #3 on 2/12/24 at 3:00 PM, she observed Resident #54 had scratch marks on his abdomen and arms and the dark substance under his nails appeared to be dried blood. She confirmed his nails were long and dirty and needed to be cleaned and trimmed to protect his skin and to honor his preference for short nails. She stated the CNAs were to do residents' nail care on bath days and it was her responsibility to make sure this was done. She confirmed nail care for this resident had not been done recently.

On 2/12/24 at 3:20 PM, the Assistant Director of Nursing (ADON) confirmed Resident #54's nails were long and dirty and scratches on his abdomen and arms were noted. The ADON confirmed the resident's nails were long and dirty with a substance that appeared to be old dried blood from scratching his skin and this resident's nails were not kept clean and trimmed to the length the resident preferred. She confirmed the facility failed to provide the resident's ADL nail care assistance for his nail care needs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 677	Continued From page 75 During an interview on 2/12/24 at 4:55 PM, the DON confirmed the facility failed to ensure adequate ADL nail care for a dependent resident was done. She confirmed the resident's nails were not kept clean and short as preferred by the resident. Record review of Resident #54's Admission Record revealed the resident was admitted to the facility on 11/9/23. Diagnoses included Muscle Weakness and Lack of Coordination. Record review of Resident #54's MDS with an ARD of 1/5/24, Section GG revealed for personal hygiene, Resident #54 required partial/moderate assistance. Resident #54's BIMS score was 11 which indicated the resident had moderate cognitive impairment.	F 677		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, record review, facility policy review, and job description review, the facility failed to recognize and assess risk factors for a resident receiving an opioid pain medication and failed to	F 684	1. On 02/14/2024, Resident #20 received an order for a laxative and was administered a laxative and abdominal x-ray. On 02/15/2024, resident #20 still had no results from laxative, provider was	3/19/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 684	Continued From page 76 ensure that a resident received care in accordance with professional standards of practice, for one (1) of two (2) residents reviewed for pain management. Resident #20. Resident #20 experiencing prolonged nausea, vomiting, and an infrequent passage of stool (constipation) with a potential outcome for fecal impaction, and bowel obstruction (blockage). Findings Include: Record review of the facility policy titled "Change in a Resident's Condition or Status" with a review date of 7/24/23 revealed "Policy Statement: Our facility notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status...Policy Interpretation and Implementation: 1. The nurse will notify the resident's attending physician or physician on call when there has been a (an):...d. significant change in the resident's physical/emotional/mental condition; e. need to alter the resident's medical treatment significantly;... i. specific instruction to notify the physician of changes in the resident's condition ...." Record review of the Job Description for the Director of Nursing (DON) with a revision date of 8/10/17 revealed, "Summary: To manage overall operation of the Nursing Services Department in accordance with Company Policies, standards of nursing practices and governmental regulations so as to maintain excellent care of all the Residents' and employee's needs ....Essential Duties And Responsibilities:... Conduct regular rounds to review care. Assess resident's physical and psychosocial status. Monitor care activities	F 684	notified, and order received for enema with results noted. On 02/11/2024 the resident was assessed by Licensed Practical for nausea and vomiting with new orders implemented. 2. All residents who take opioids have the potential to be affected by the alleged deficient practice. 3. On 02/14/2024, the Director of Nurses (DON) was educated on quality of care to ensure that residents receive treatment and care in accordance with professional standards of practice, comprehensive care plan and the resident's choices by the Regional Nurse Consultant (RNC). On 03/04/2024, residents receiving an opioid pain medication were assessed for side effects with no concerns. Provider notification and orders were updated to include side effect observations each shift to observe for nausea, vomiting, abdominal pain, abdominal distention, decreased appetite, and difficulty with bowel movements. On 03/08/2024, licensed staff were educated regarding the side effects of opioid medications, observation orders, and signs and symptoms to report to the provider by Assistant Director of Nursing. Starting on 03/08/2024, the Medical Records Nurse will review all new opioid pain medication orders to ensure that observations for nausea, vomiting, abdominal pain, abdominal distention, decreased appetite, and difficulty with bowel movements are in the supplementary documentation of the order. Beginning on 02/14/2024, the Medical Records nurse will review the electronic health record dashboard for any	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 684	Continued From page 77 and documentation to ensure the delivery of nursing care according to the physician's order, care plans, and established standards and facility policies ..." Record review of Resident #20's "Order Summary Report" revealed an order dated 1/02/24, "Norco Oral Tablet 7.5 -325 MG (milligrams) (Hydrocodone-Acetaminophen) Give 7.5 mg (milligrams) by mouth every 6 (six) hours related to Pain ..." Record review of Resident #20's "Order Summary Report" with active orders as of 2/13/24, revealed an order dated 12/13/23, "Tramadol HCL (Hydrochloride) Tablet 50 MG (milligrams) Give 1 tablet by mouth every 12 (twelve) hours as needed for pain." Also revealed an order dated 12/13/23, "Tramadol HCL (Hydrochloride)Tablet 50 MG (milligrams) Give 2 (two) tablets by mouth every 12 (twelve) hours as needed for pain ..." Record review of Resident #20's "BM (bowel movement) Report" dated 1/29/24 through 2/13/24, revealed one (1) medium BM documented on 2/04/24. All other days were documented as "None" or "Not Applicable", which indicated the resident had not had a BM in 9 (nine) days. Record review of Resident #20's "Pain Care Plan" revealed under, "Interventions/Tasks: ... Observe/document for side effects of pain medication. Observe for constipation;... nausea; vomiting;...Report occurrences to the physician..." An observation and interview with Resident #20 on 2/11/24 at 3:19 PM, revealed her lying in a	F 684	resident that has not had bowel movement in 3 days. The Medical Records Nurse will notify the Director of Nurses in clinical meeting for intervention and follow through. The Director of Nurses will ensure that the intervention is completed. 4. Starting on 03/08/2024, the Director of Nurses will review five alternating residents receiving opioid medications will be audited 5 times a week for four weeks, for side effects of opioid medications, with appropriate action taken immediately. This will be followed by bi-weekly audits for two weeks, then monthly audits for three months by the Director of Nurses. The Director of Nurses will report audit findings to the Quality Assurance and Performance Improvement committee meeting monthly for review and/or revision. Starting on 02/14/2024, the Medical Records nurse will audit bowel movements five times a week. Medical Records nurse will report to Director of Nurses, who will then take appropriate action and report audit findings to the Quality Assurance and Performance Improvement committee meeting monthly, starting 03/19/2024, for 6 months for review and/or revision of the plan then as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 684	Continued From page 78	F 684		

fetal position at the foot of the bed. A small garbage can was located on the floor close beside the resident and the resident stated she was sick to her stomach. The resident had a washcloth in her hand and was wiping her face.

An observation and interview with Resident #20 on 2/11/24 at 6:07 PM, revealed she was lying on her right side in bed and was still nauseated and could not eat dinner. She stated, "I'm just sick."

An interview with Certified Nurse Aide (CNA) #2 on 2/12/24 at 8:35 AM, revealed Resident #20 had been nauseated, dry heaving, and vomiting for the three (3) weeks since she had been employed at the facility. She revealed that she had reported it to the medication nurse every day that she worked.

An interview with the Director of Nursing (DON) on 2/12/24 at 3:55 PM, revealed Resident #20 had a significant decline after she fell in December 2023, and received a fracture of the T-12 vertebrae and had to be placed on pain medications. She revealed to her knowledge the resident had not experienced any nausea and vomiting until yesterday when the State Agency brought it to her attention. The DON confirmed that she should have been aware of what was going on with the resident.

Record review of the "Occupational Therapy Progress Notes" dated 2/01/24 revealed, "Patient refused: pt (patient) is refusing to eat and has poor appetite. Pt (patient) c/o (complains of) nausea almost every day, but is not eating even with max encouragement and assist from therapist." ... Also revealed under, "Assessment and Summary of Skilled Services: ... therapist

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 684	Continued From page 79	F 684		

encouraging pt (patient) daily to eat and providing assist, but pt (patient) refuses to eat and c/o (complains of) nausea..."

An interview with the Assistant Director of Nursing (ADON) on 2/13/24 at 5:10 PM, revealed that the aides were responsible for documenting the bowel movements every shift. She revealed if a resident did not have a bowel movement in 3 days, it would trigger the charting system dashboard and would alert the Director of Nursing (DON). She revealed that the dashboard was checked every morning by the DON, after the daily stand-up meeting, to identify which residents had not had a bowel movement. The ADON explained that the DON would then check with the nurses and the aides on the floor to identify if a resident had a BM, and maybe it was not documented. If a resident had not, a process was followed through with pulling a standing order for a laxative. She revealed that Resident #20's BM report was not firing to the dashboard to alert the DON of no BM.

An interview with the DON on 2/13/24 at 5:36 PM, confirmed that the facility did not have a monitoring tool in place for Resident #20 to monitor for the common side effects of an opioid pain medication such as constipation, nausea, and vomiting. She revealed that Resident #20's BM (bowel movement) report was not firing to the charting system database to alert her that the resident had not had a BM in 3 days. The DON stated she would tell Resident #20's nurse to administer a laxative and follow up with the resident in the morning.

During an interview and record review on 2/13/24 at 5:50 PM, with Licensed Practical Nurse (LPN)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 684	Continued From page 80	F 684		

#3 revealed she had not received in a report from the previous shift that Resident #20 needed a laxative. LPN #3 looked at the BM (bowel movement) summary report and confirmed that the last BM was documented on 2/4/24 which was 9 days prior. She stated that the facility had standing orders for a laxative that could be administered.

An interview with LPN #3 on 2/14/24 at 8:50 AM, revealed that she did not administer a laxative to Resident #20 yesterday on the 3-11 shift and stated that she had not been directed by anyone to do so.

An interview with the DON on 2/14/34 at 9:20 AM, revealed that she was unsure if Resident #20 had a BM overnight an stated that with everything going on in the facility, she forgot to notify the nurse caring for the resident to administer a laxative. The DON explained if a laxative had been administered, it would be documented on the Medication Administration Record (MAR), and she confirmed that it was not documented. She stated, "I will get someone to do it."

An interview with the DON on 2/14/24 at 2:55 PM, revealed that she had not notified the nurse on the floor to give Resident #20 a laxative. She stated that the resident's physician had not been contacted related to the no bowel movement (BM) in 10 days.

An interview with the Regional Nursing Consultant (RNC) and Regional Director of Operations (RDO) on 2/14/24 at 3:05 PM, revealed they were not aware of Resident #20's condition of not having a BM since 2/04/24. They acknowledged that the situation should be taken

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 684	Continued From page 81 seriously, and the physician should have been notified immediately and that they would get right on it. Record review of the Progress Notes for Resident #20 dated 2/14/24 at 15:52 (3:52 PM) revealed, "Note Text: Resident has not had a BM since 2/04/24. This nurse notified (Proper Name of Physician) and he gave a one time order for lactulose. He also gave an order for Xray flat and upright...." Record review of Resident #20's Abdominal X-Ray report dated 2/14/24 revealed under, "Impression: 1. No free air or bowel obstruction. 2. Moderate stool in colon compatible with constipation..." Record review of the "Transfer/Discharge Report" revealed the facility admitted Resident #20 on 1/24/22 with medical diagnoses that included Alzheimer's disease, Rheumatoid arthritis, Primary open-angled glaucoma, and Wedge compression fracture of T 11-T 12 vertebra, subsequent encounter for fracture with delayed healing. Record review of Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/10/24 revealed a Brief Interview for Mental Status (BIMS) score of 03 which indicated the resident had severe cognitive impairment.	F 684		
F 692 SS=J	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and	F 692		3/19/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 692	Continued From page 82 percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, record review, and facility policy review, the facility failed to maintain acceptable parameters of nutrition for two (2) of six (6) residents sampled for nutrition as evidence by: Resident #13 and Resident #20 1) failed to recognize, evaluate, and address a resident's nutritional needs, which resulted in an unintended significant weight loss of 6.92% (percent) in one (1) month, which further led to a significant weight loss of 17.52% in four (4) months. Resident #13. The facility's failure to consult a Registered Dietician (RD), notify the attending physician of a significant change in condition, and act upon the residents' weight loss, placed the resident, and all other residents residing in the facility at risk for serious harm, serious injury, serious impairment, and possibly	F 692	1. On 02/11/2024, antiemetic medication was ordered for resident #20. On 2/13/2024, Inservice for Abuse and Neglect for staff began by the Assistant Director of Nursing. On 02/13/2024, Social Services and Medical Records Nurse interviewed all residents for nausea and vomiting and reported to provider. On 02/13/2024, the Director of Nursing notified providers of residents with complaints of nausea and vomiting. On 02/13/2024, all residents were audited for weight loss by the Director of Nursing, Regional Nurse Consultant, and Minimum Data Set Nurse. On 02/13/2024, Providers for all residents with weight loss were notified by the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 692	Continued From page 83 death. 2) failed to identify and address a resident at risk for malnutrition due to prolonged nausea and vomiting, and failure to identify a decrease in food intake due to pain and nausea resulted in an unintended significant weight loss of 40.5 pounds in six (6) months. Resident #20. The facility's failure to implement a Registered Dietician (RD) recommendation, notify the attending physician of a significant change in condition, and address the residents' prolonged symptoms of nausea and vomiting, and decreased food intake placed the resident and all other residents residing in the facility at risk for serious harm, serious injury, serious impairment, and possibly death. The facility's neglect also resulted in a functional decline for Resident #20, which possibly resulted in the resident's admission to hospice services on 2/14/24. The State Agency (SA) identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 11/02/23 when the facility failed to recognize, evaluate, and address Resident #13's nutritional needs, which resulted in an unintended significant weight loss of 6.92% (percent) in one (1) month, which further led to a significant weight loss of 17.52% (percent) in four (4) months. The facility's failure to consult a Registered Dietician (RD), notify the attending physician of a significant change in condition, and act upon the residents' weight loss, placed the resident, and all other residents residing in the facility at risk for serious negative outcomes. The IJ and SQC existed at: CFR §483.25(g)(1) Nutrition/Hydration Status	F 692	Director of Nursing, Assistant Director of Nursing, and Medical Records Nurse. On 02/13/2024, a medication review for all residents with weight loss was conducted by the medical director. On 02/13/2024, Dietary Manager and Minimum Data Set Nurse audited all Registered Dietician Recommendations for the last 90 days were reviewed with provider and new orders and implemented. On 02/13/2024, all nutrition care plans were audited by the Minimum Data Set Nurse and updated to reflect dietary recommendations. Ad Hoc Quality Assurance and Performance Improvement meeting was held on 02/13/2024. On 02/13/2024, One-on-One in-services with the Director of Nursing, Dietary Manager, Assistant Director of Nursing, Medical Records Nurse, and Minimum Data Set Nurse regarding weights, care plans, notifying physician, Quality Assurance and Performance Improvement meetings, Registered Dietitian Recommendations, Documentation, and Administration were conducted by the Regional Nurse Consultant. On 02/13/2024, the Regional Director of Operations conducted and One-on-One in-service with the Administrator regarding weights, care	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 692	Continued From page 84 Maintenance - F692- Scope /Severity "J" The facility administrator was notified of the IJ and SQC on 2/13/24 at 4:30 PM and provided the IJ Template. The facility provided an acceptable Removal Plan on 2/14/24, in which they alleged all corrective actions to remove the IJ were completed on 2/13/24 and the IJ removed on 2/14/24. The SA validated the Removal Plan on 2/20/24 and determined the IJ was removed on 2/14/24. Therefore, the scope and severity for 42 CFR §483.25(g)(1) Nutrition/Hydration Status Maintenance - F692, was lowered from a "J" to a "D" while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings Include: Review of the facility policy titled "Weight Assessment and Intervention" with a review date of 8/2003 revealed, "Policy Statement: Resident weights are monitored for undesirable or unintended weight loss or gain .... Weight Assessment: 1. Residents are weighed upon admission and at intervals weekly or monthly or as ordered by the physician .... 3. Any weight change of 5% or more since the last weight assessment is retaken the next day for confirmation. a. If the weight is verified, nursing will immediately notify the dietician in writing. ... 5. The threshold for significant unplanned and undesired weight loss will be based on the following criteria ... a. 1 month- 5% weight loss is significant; greater than 5% is severe. b. 3	F 692	plans, notifying physician, Quality Assurance and Performance Improvement meetings, Registered Dietitian Recommendations, Documentation, and Administration. On 02/13/2024, the nurses who provided care to resident # 20 for previous three weeks were provided one-on-one for reporting changes of condition to provider, documentation, and following plan of care and provided posttest to confirm understanding by the Director of Nursing and Assistant Director of Nursing. On 02/13/2024, Social Services and Medical Records nurse interviewed residents with a BIMS of 10 or higher to ensure residents were feeling safe in the environment and are free of health and safety concerns. On 02/14/2024, resident #20 was ordered appetite stimulant. On 02/14/2024, Resident #20 was admitted to hospice services. On 2/15/2024 resident #13 was ordered fortified cereal and fortified mashed potatoes. 2. All residents in the facility have the potential to be affected by the alleged negligent practices. 3. On 02/13/2024, appropriate staff were educated on nutritional status, care plans, reporting, documentation, and notifying provider by Assistant Director of Nurses. Starting on 03/07/2024 and completed on 03/08/2024, the Rehab Director	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 692	Continued From page 85 months- 7.5% weight loss is significant; greater than 7.5% is severe. c. 6 months- 10% weight loss is significant; greater than 10% is severe ...." Under, "Evaluation: ... 2. The physician and the multidisciplinary team identify conditions and medications that may be causing anorexia, weight loss or increasing the risk of weight loss." Review of the facility policy titled "Nutritional Assessment" with a review date of 7/24/23 revealed, "Policy Statement: As part of the comprehensive assessment, a nutritional assessment, including current nutritional status and risk factors for impaired nutrition, shall be conducted for each resident...Policy interpretation and Implementation: 1. The dietician, in conjunction with the nursing staff and healthcare practitioners, will conduct a nutritional assessment for each resident upon admission (within current baseline assessment timeframes) and as indicated by a change that places the resident at risk for impaired nutrition. ... 4. The multidisciplinary team shall identify, upon the resident's admission and upon his or her change of condition, the following situations that place the resident at increased risk for impaired nutrition. ... d. Medication changes - includes changes resulting in loss of appetite, nausea, constipation, lethargy, decreased absorption, swallowing difficulties., etc .... h. Fluid and nutrient loss-prolonged fluid and nutrient loss secondary to diarrhea and/or vomiting that may increase nutritional requirements..." Resident #20 Cross reference F580, F692, F656 An observation and interview with Resident #20 on 2/11/24 at 3:19 PM, revealed her lying in a fetal position at the foot of the bed with a garbage	F 692	in-serviced therapy staff to notify nurse of changes in resident conditions and concerns promptly. Beginning on 02/13/2024, the Medical Records nurse will review the nutritional report in the electronic health record for any residents with decreased meal intake percentage in clinical meetings. The Medical Records nurse will ensure that concerns are communicated to the provider, interventions are put in place and the plan of care is updated at this time. Beginning on 02/13/2024, the dietary recommendations will be reviewed weekly by the DON and Dietary manager. The recommendations will be reviewed in clinical meetings for completion and documented in the resident's chart with the plan of care updated. 4. Starting 02/14/2024, the Director of Nurses will review the progress notes 5 times per week for changes in resident condition for 4 weeks, then weekly for 4 weeks, then biweekly for 2 months, then monthly for 2 months. The Director of Nursing will take immediate corrective action as needed. Starting 03/04/2024, the Administrator will interview 5 alternating residents weekly to ensure that residents feel safe and are free of health and safety concerns for 8 weeks, then bi-weekly for 2 months, then monthly for 2 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 692	Continued From page 86 can located on the floor beside the resident. The resident stated she was sick to her stomach and had a washcloth in her hand and was wiping her face. The resident's color was pale, lips were dry, and she was thin in appearance. An observation and interview with Resident #20 on 2/11/24 at 6:07 PM, revealed her lying on her right side in bed. The resident stated she was nauseated and could not eat dinner. She stated, "I'm just sick." An interview on 2/11/24 at 6:12 PM, with Certified Nurse Aide (CNA) #7 revealed Resident #20 refused her dinner tray due to nausea and vomiting. She stated she was unsure how long the resident had been sick. An observation of Resident #20 on 2/12/24 at 8:29 AM, revealed her lying on her right side in bed. The garbage can was located on the floor, close by the resident. The breakfast tray was located on the bedside table untouched. CNA #2 entered the resident's room, and stated the resident refused to eat or drink due to nausea. CNA #2 removed the tray cover, and the resident began to retch and vomited a small amount of clear substance. The resident was weak, pale, and her lips were dry. An interview with CNA #2 on 2/12/24 at 8:35 AM, revealed she had worked at the facility for three (3) weeks and Resident #20 had refused to eat or drink since then. She explained that the resident had been nauseated, dry heaving, and vomiting for the past three (3) weeks since she had been employed at the facility. CNA #2 confirmed that she had reported the symptoms to the medication nurse every day that she worked.	F 692	The administrator will take immediate corrective action as needed and notify appropriate authorities as needed. The Administrator will report findings to the Quality assurance and performance improvement committee (QAPI) monthly for review and or revision of the plan. Starting 02/13/2024, the Minimum Data Set Nurse will audit nutrition care plans weekly times 4 weeks, then bi- weekly times 2 months, then monthly times 3 months for appropriate interventions. The Minimum Data Set Nurse will take immediate corrective action as needed. The MDS nurse will report findings to the Quality assurance and performance improvement committee (QAPI) monthly for review and or revision of the plan. Starting 02/13/2024 the Medical Records Nurse and the Dietary Manager will audit the dietary recommendations to ensure receipt, provider notification, documentation, and implementation weekly times 4, then bi-weekly times 2 months, then monthly times 3 months. The Medical Records Nurse and the Dietary Manager will take immediate corrective action as needed. The Dietary Manager will report findings to the Quality assurance and performance improvement committee (QAPI) monthly for review and or revision	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 692	Continued From page 87 An interview with CNA #1 on 2/15/24 at 8:35 AM, revealed Resident #20 refused breakfast due to nausea. She stated that she had notified the nurse each time that she witnessed the resident with nausea and vomiting or refusing to eat and drink. Record review of Resident #20's "Progress Notes" from 11/01/23 through 2/11/24, revealed there was not any documentation that the resident had nausea and vomiting or that she refused meals. Record review of the "Occupational Therapy Progress Notes" dated 2/01/24 revealed, "Patient refused: pt (patient) is refusing to eat and has poor appetite. pt (patient) c/o (complains of) nausea almost every day, but is not eating even with max encouragement and assist from therapist." ... Also revealed under, "Assessment and Summary of Skilled Services: ... therapist encouraging pt (patient) daily to eat and providing assist, but pt (patient) refuses to eat and c/o (complains of) nausea." ... Record review of the "Order Summary Report" for Resident #20 revealed an order dated 2/11/24 at 1827 (6:27 PM), "Ondansetron HCL (Hydrochloride) Tablet 4 (four) MG (milligrams) Give 1 (one) tablet by mouth every 6 (six) hours as needed for Nausea and Vomiting" ... Record review of Resident #20's January and February "Medication Admission Record" (MAR) revealed, there was not a physician's order for nausea/vomiting medication before the new order for Ondansetron HCL started on 2/11/24, which indicated the resident's symptoms of prolonged	F 692	of the plan. The Director of Nurses will review weights five (5) times a week times 2 months for changes. The DON will take immediate corrective action as needed. The DON, Administrator, Minimum Data Set Nurse, Dietary Manager, and Medical Records Nurse will report findings to the Quality assurance and performance improvement committee (QAPI) monthly, starting 03/19/2024, for 6 months for review and or revision of the plan then as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 692	Continued From page 88	F 692		

nausea and vomiting were left untreated.

Record review of the "Meal Intake Documentation Report" completed by the Certified Nurse Aides (CNAs) revealed, Resident #20 refused eighteen (18) meals from 12/18/23 through 12/31/23. She refused thirty-one (31) meals in the month of January 2024, with a total of thirty-nine (39) meals consumed at 0-25% (percent), and she refused sixteen (16) meals from 2/01/24 through 2/11/24, with a total of fourteen (14) meals consumed at 0-25% (percent).

Record review of Resident #20's "Order Summary Report" revealed an order dated 1/08/24, "Weekly weights x (times) 4 (four) weeks one time a day every 7 day(s)" ...

Record review of Resident #20's "Weight Summary" revealed the following weights:

8/03/23 - 154.5 pounds

9/07/23 - 152.2 pounds

10/5/23 - 147.6 pounds

11/01/23 - 145.4 pounds

12/04/23 - 145 pounds

1/03/24 - 132.4 pounds

1/10/24 - 129.6 pounds

1/16/24 - 124 pounds

1/23/24 - 133.2 pounds

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 692	Continued From page 89 1/30/24 - 122.8 pounds 2/06/24 - 114 pounds 02/15/24 - 110 pounds Record review of Resident #20's weights revealed a significant weight loss of 13.9% (percent) in one (1) month, 21.6% (percent) in three (3) months, and 26.2% (percent) in six (6) months. Record review of the" Order Summary Report" for Resident #20 revealed an order dated 1/04/24, "Regular diet Regular texture, Regular consistency" ... Also revealed an order dated 1/04/24, "Med Pass 2.0 two times a day for supplement." An interview with the Director of Nursing (DON) on 2/11/24 at 3:55 PM, revealed Resident #20's condition had declined over the past couple of months related to her diagnosis of dementia. She explained that the resident had a significant decline after she fell in December 2023, and received a fracture of the T-12 vertebrae and had to be placed on strong pain medications. She stated, to her knowledge, the resident had not experienced any nausea and vomiting until yesterday when the Survey Agency brought it to her attention. She stated none of the staff had reported it to her and confirmed that she should be aware of what was happening with the resident. She revealed she was aware that the resident was not eating or drinking and had been refusing meals. The DON stated she had made the physician aware of the resident's decline, and the significant weight loss, and the Registered Dietician (RD) had evaluated her.	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 692	Continued From page 90	F 692		

An interview with Licensed Practical Nurse (LPN) #3 on 2/11/24 at 4:20 PM, revealed Resident #20 had a decline over the past several weeks. She explained that the resident would not eat or drink anything, including the med pass supplement. She stated that usually they cannot get her to take her medications and that the resident would eat crushed ice chips, but that's about it. LPN #3 explained that she noticed a change after the resident fell and hurt her back and was in a lot of pain. She confirmed that she had not notified the resident's physician of the change in condition.

A telephone interview with Medical Director on 2/12/24 at 6:05 PM, revealed the staff had contacted him last night regarding Resident #20 having nausea and vomiting, and he had ordered Zofran (Ondansetron) as needed. He confirmed that the staff had not contacted him or made him aware of the resident's decline in condition or her refusal to eat or drink. He stated that he was not notified of her significant weight loss (40.5 pounds in 6 months) or the Registered Dietician (RD) recommendations. He confirmed Resident #20's current condition was serious and stated what you have relayed to me screams neglect.

Record review of the "Emergency Room (ER) Report" dated 12/17/23, revealed Resident #20 was transported to the ER after suffering an unwitnessed fall at the facility with complaints of back pain. Findings of the CT (Cat Scan) of the Spine Lumbar without contrast dated 12/17/23 revealed," There is a T-12 vertebral fracture involving both the superior and inferior endplates as well as the posterior cortex." ...

Record review of Resident #20's Order Summary

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 692	Continued From page 91 Report revealed an order dated 1/08/24, "RD (Registered Dietician) consult" ... Record review of the "Consultant Registered Dietician (RD) Note" dated 12/27/23, for Resident #20 revealed the RD (Registered Dietician) recommended, "Med Pass 2 oz (ounces) BID (twice daily), weekly weights x (times) 4 (four) weeks, and add Fortified Pudding BID (twice daily) at lunch and dinner" ... Record review of the "Consultant Registered Dietician (RD) Note" dated 1/5/24, for Resident #20 revealed, "Resident w/(with) significant wt (weight) loss x (times) 1 (one) mo (month) (-9%) and x (times) 6 (six) mo (months) (13.7%) (percent). Po (by mouth) intake likely not meeting nutritional needs. Resident is at risk for skin breakdown and wt (weight) loss d/t (due to) decreased appetite ... NO N/V/c/D (nausea, vomiting, complaints of diarrhea) documented." ... Also revealed under REC (recommendations): "Resident may benefit from an appetite stimulant, please document % (percentage) of supplement consumed daily, add fortified pudding BID (twice daily) at lunch and dinner, weekly weights x (times) 4 (four) weeks to assure stable weight" ... Record review of the "Consultant Registered Dietician (RD) Note) dated 2/10/24, for Resident #20 revealed, "Resident w/(with) significant wt (weight) loss x times 1 (one) mo (month), x (times) 3 (three) mo (months) and x (times) 6 (six) mo (months) ... consuming <25% w/(with) refusals of meals ... Po (by mouth) intake likely not meeting nutritional needs ... NO N/V/c/D (nausea, vomiting, complaints of diarrhea) documented." ... Also revealed under REC (recommendations): "Resident may benefit from	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 692	Continued From page 92	F 692		

an appetite stimulant, please document % of supplement consumed daily, weekly weights x 4 weeks to assure stable weight, if po (by mouth) intake and wt (weight) status does not improve, resident may benefit from an alternate means of nutrition support."

Record review of the "Order Summary Report" for Resident #20 revealed there was not a physician's order for fortified pudding at lunch and supper or a medication to stimulate appetite per Registered Dietician (RD) recommendations.

Record review of Resident #20's Physician Nursing Home Visit dated 1/26/24 revealed, "No concerns reported by the nursing staff ...." The physician progress note did not identify any documentation to support the resident's nausea and vomiting or weight loss.

An interview with Licensed Practical Nurse (LPN) #2 on 2/13/24 at 7:45 AM, revealed Resident #20 was not drinking the med pass supplement, and was refusing meals. She stated that the resident had been refusing meals for several weeks. She revealed that the resident's family was highly involved with her care, and the resident would report nausea to them, and they would come and notify her.

An interview with the Dietary Manager (DM) on 2/13/24 at 8:13 AM, revealed that she was new to the role and had been in the position since June 2023. She revealed that the facility had weekly PAR (Patients at Risk) meetings where the weights were discussed. She stated all the Department Heads attend the meetings. The DM revealed, if a resident should need a RD (Registered Dietician) consult, she would notify

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 692	Continued From page 93	F 692		

the RD after the weekly PAR meeting by texting or calling. She stated that the RD would usually text her back to let her know she had the resident down on her list. She revealed that the RD did not come to the facility and did all her consultations remotely. She explained that the RD was consulted on Resident #20 in January 2024, but confirmed that she had not seen any RD recommendations. She stated that the resident had never received fortified pudding, and to her knowledge, had never started on an appetite stimulate. She explained that the facility had trouble getting the RD recommendations. The DM stated she just realized last week on Friday 2/9/24 that the RD recommendations were going to her spam email. She revealed that she tried to open the email and the email read it was quarantined. She revealed that she told the Director of Nursing (DON) that she was not receiving anything from the RD, and she thought the DON had texted her. She revealed that the Administrator had been going into all the residents 'progress notes and printing out the recommendations to make sure they were being implemented. She confirmed that lack of implementation of the RD recommendations could cause the resident to have weight loss and malnourishment.

A telephone interview with the Registered Dietician (RD) on 2/13/24 at 9:56 AM, revealed that she worked remotely and tried to be onsite every 60-90 days. She revealed that her last visit to the facility was December 16, 2023. The RD explained that she had access to the Electronic Medical Record (EMR) and was able to chart under the residents' Progress Notes or under the Miscellaneous tab. She revealed that she was usually notified by the Director of Nursing (DON)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 692	Continued From page 94	F 692		

or the Dietary Manager (DM) when a resident needed a dietary consultation. The RD stated she was notified in late December that Resident #20 needed to be seen due to a significant change. She revealed that she recommended med pass 2 ounces twice daily as a supplement, weekly weights and fortified pudding added with lunch and dinner. She revealed that she also did a consultation on Resident #20 on 1/5/24 and 2/10/24 and recommended that the resident would benefit from an appetite stimulant. She explained that she emailed all her recommendations to the Administrator (ADM), Director of Nursing (DON), Dietary Manager (DM), and the Regional Nursing Consultant (RNC). She explained that she marked on the recommendations if the physician needed to be contacted for a physician order. She confirmed that Resident #20's recommendation was marked to contact the physician for an appetite stimulant and adding the fortified pudding. She stated that she was unable to contact the doctor or write orders because she did not have the authority with her contract with the facility. She stated that she had not been contacted by anyone from the facility reporting that they had not received Resident #20's dietary recommendations.

An interview with the Director of Nursing (DON) on 2/13/24 at 10:38 AM, revealed Resident #20 functional status had declined since her fall and after reviewing the progress notes, she observed there was no documentation to support a decline, nausea, and vomiting or food refusal. She revealed before the fall the resident was ambulatory, rarely in bed, and she took herself to the bathroom. She revealed that she would sit up in a chair in her room. She stated after the fall the resident required more help with her Activities of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 692	Continued From page 95	F 692		

Daily Living (ADLs), stayed in bed, became incontinent, had more falls, and required the staff to assist with eating. She confirmed that the facility should have notified the physician immediately when the decline came about, and verbalized that was a failure on their part. She explained that the facility had spoken with the son about placing the resident on hospice today, and he had agreed. She explained that she knew it looked bad that they had consulted hospice, but she stated we had talked to the son before, and he thought she might recover. The DON stated that the facility did not reach out to the physician to inquire about drawing labs or any intravenous fluids throughout these months of the resident refusing to eat or drink. She stated that she did report the weight loss to the physician while he was inside the facility. She stated, "I do not recall the date or month I notified him." She confirmed that she did not have documentation to support her notification. She stated that the facility was not receiving any of the dietary recommendations, and the Dietary Manager (DM) determined that the emails were going to her junk folder. She explained that the Administrator was going into the resident notes and printing them out to ensure they were all implemented. The DON stated that the RD would also add her notes to the Electronic Medical Record (EMR) and would not tell anyone. She revealed that she had texted the RD to tell her that the recommendations were not received, and the RD would reply that she would resend them. The DON revealed that she had never received any emails from the RD, and confirmed that she had not gone into her junk email to search and see if they came to her that way. The DON stated, "I have over 700 junk emails and I do not have time to do that."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 692	Continued From page 96	F 692		

An interview with the Administrator (ADM) on 2/13/24 at 2:10 PM, revealed the Registered Dietician (RD) worked remotely, and she had seen her in the facility twice. She explained that they were in the process of trying to find a RD onsite. She revealed that the facility usually communicates with the current RD through email or text messages and the last RD recommendation she had received by email was in August 2023. She stated that the Dietary Manager (DM) had received some, but they went to her spam folder encrypted. She explained that she had not reached out to the RD herself to follow up and that the facility had not started an audit and stated they tried to go over the recommendations in the High-Risk meetings. She stated that Resident #20 had been discussed in January 2024 during a PAR (patients at risk) meeting. The ADM confirmed that the Dietary Recommendations for Resident #20 had not been implemented and that the facility failed to document the significant changes that occurred in the resident's condition. She stated, "I know the documentations not there." She revealed that she was told the Director of Nursing (DON) had reached out to the physician and stated, "It looks bad on our part."

An interview with Social Services (SS) on 2/13/24 at 3:00 PM, revealed she had reached out to the family of Resident #20 about the functional decline on 1/10/24. She revealed that the son did not want to do hospice at that time and was hoping the resident would perk up. She explained that since then, she followed up with the family and explained that the resident continued to decline and asked them to reconsider hospice services again.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 692	Continued From page 97	F 692		

Record review of the "Progress Notes" for Resident #20 dated 2/14/24, "Proper Name Hospice consulted per md order and family request ... for declining condition related to Alzheimer's disease ..."

An interview with the Minimum Data Set (MDS) Nurse on 2/14/24 at 5:23 PM, revealed that she did a significant change MDS after Resident #20 fell in December 2023, and after it was identified in the facility's clinical meeting that the resident had a significant weight loss in January 2024. She revealed that after the fall, the resident declined in her ability to get out of bed, and she was no longer able to sit in a chair, which was what the resident liked to do. She explained that the resident experienced increased pain, worsening incontinence and was required to wear a back brace when she was out of the bed. She stated that staff had identified the weight loss, and, in her opinion, it was being addressed. She confirmed that the documentation was absent to support a decline in the residents' condition, and stated she went off what was discussed in the High-Risk meetings. She revealed that she was aware that the resident did not have a physician order for the fortified pudding or an appetite stimulant that was recommended by the Registered Dietician (RD).

Record review of the "Transfer/Discharge Report" revealed the facility admitted Resident #20 on 1/24/22 with medical diagnoses that included Alzheimer's disease, Rheumatoid Arthritis, Primary Open-angled Glaucoma, and Wedge Compression Fracture of T 11-T 12 vertebra, subsequent encounter for fracture with delayed healing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 692	Continued From page 98	F 692		

Record review of Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 01/10/24 revealed a Brief Interview for Mental Status (BIMS) of 03 which indicated the resident had severe cognitive impairment. Prior MDSs dated 09/18/23 revealed a BIMS of 11, MDS dated 12/11/23 revealed a BIMS of 9.

Resident #13 Cross reference F580, F600, F656

During an observation and interview on 2/13/24 at 11:05 AM, Resident #13 appeared comfortable lying in bed and stated she had lost weight while in the facility. She revealed there were times she did not eat well and she was not on supplements.

During an interview on 2/14/24 at 11:40 AM, the Director of Nursing (DON) revealed Resident #13 had a significant weight loss which was not reported to the physician for interventions, therefore, her weight continued to decrease. She stated the Registered Dietician (RD) had not been consulted concerning the significant weight loss. She confirmed that due to the physician and the RD not being notified, the resident had a weight loss that could have possibly been avoided if interventions had been put in place for the resident's nutritional well-being. She confirmed the facility neglected to recognize, evaluate, and address the resident's weights, failed to notify the physician of the weight decline, and failed to consult the RD, therefore, appropriate evaluations and interventions were not ordered or initiated which put the resident at risk for a continued weight loss. She confirmed these failures led to a significant weight loss of 6.92% during Resident #13's first month at the facility and to a 17.52% weight loss during her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 692	Continued From page 99	F 692		

first four months at the facility.

An interview with the facility's Regional Nurse Consultant on 2/15/24 at 8:45 AM, revealed the physician nor the nurse practitioner were notified of Resident #13's significant weight loss and therefore, no interventions were initiated and weight continued to decline. She stated the initial consult with the Registered Dietician (RD) was on admission due to her wounds and once her weight was trending down, no additional consults were made. She confirmed the facility neglected to identify, evaluate, and intervene for nutritional concerns and, therefore, an avoidable weight loss occurred due to the facility's failure to appropriately manage the resident's nutritional needs.

During an interview on 2/15/24 at 12:00 PM, the Dietary Manager confirmed she was unaware of Resident #13's significant weight loss and failed to ensure the Registered Dietician was notified of the weight loss concern.

Record review of "Weights and Vitals Summary" revealed Resident #13's weight on 10/3/23 of 166.1 pounds and a weight on 11/2/23 of 154.6 pounds which listed a comparison weight of an 11.5 pound decrease and a 6.9% weight loss. Resident #13's weight on 2/5/24 was 137 pounds and compared to the admission weight 4 months previously of 166.1 pounds on 10/3/23 listed a comparison weight of a 29.1 pound decrease and a 17.5% weight loss.

Record review of Resident #13's Admission Record revealed she was admitted to the facility on 10/2/23. Diagnoses included Stevens-Johnson Syndrome, Non-pressure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 692	Continued From page 100	F 692		

Ulcers, Anxiety Disorder, Major Depressive Disorder.

Record review of Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 12/12/23 revealed a Brief Interview for Mental Status (BIMS) of 12 which indicated the resident had a moderate cognitive impairment.

The facility submitted the following removal plan:

On 02/13/2024 at 4:30 PM, the Mississippi State Department of Health (MSDH) state survey team notified the Administrator of an Immediate Jeopardy for failing to ensure processes were in place to review and implement Registered Dietician (RD) recommendations, notify the physician of weight loss, and implement interventions to address weight loss for Resident #20, who had lost 40.5 lbs in the last six months. Resident #20 also had nausea and vomiting and was not eating or drinking adequately for the last three weeks and the facility had failed to notify the physician of the significant change. The facility failed to follow care plan interventions to identify weight loss and address weight loss for Resident #20. The facility failed to have an effective Quality Assurance and Performance Improvement (QAPI) meeting to ensure all recommendations from the Registered Dietician were addressed in a prompt manner. Review of facility processes revealed that the recommendations from the registered dietician was being sent to the Dietary Manager via email and the emails were not received and not presented to the interdisciplinary team and reviewed by the provider and implemented. Interview with staff indicates that resident has had poor appetite since January, and it was not documented in the medical record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 692	Continued From page 101	F 692		

On 02/11/2024 at 6:27 PM, the facility nurse notified the provider and obtained orders for anti-emetic.

On 2/12/2024 at 9:27 am, the facility attempted to transfer resident to the emergency room for evaluation and treatment as indicated. The Responsible Party refused for resident to be sent to the emergency room on this date. The facility obtained a physician's order for hospice services.

On 02/13/2024 5:00 PM, In-services began on Abuse and Neglect for all staff by the Assistant Director of Nursing. All staff will be trained prior to returning to work. In-services began by Assistant Director of Nursing on Documentation, Provider Notification, and Change of Condition. All staff will be trained prior to returning to work.

On 02/13/2024 at 5:15 PM, Social Services and Medical Records Nurse interviewed all residents regarding Nausea and Vomiting to ensure all significant changes of conditions were reported to the providers. It was noted upon interview that nine (9) residents reported recent complaints of nausea and vomiting, one (1) resident noted to have yellow discharge from mouth and nose, 1 resident was unable to recall when nausea or vomiting occurred with no staff being knowledgeable of nausea or vomiting, two (2) residents reported nausea or vomiting after eating, 2 residents reported not having appetite or eating, 1 resident reported nausea but did not report to nurse, 2 residents reported nausea and medications received.

On 02/13/2024 at 5:30 PM, all residents were audited for weight loss by the Director of Nursing,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 692	Continued From page 102	F 692		

Regional Nurse Consultant, and Minimum Data Set Nurse. Results of weight loss audit were reviewed by the medical director (15 unplanned weight losses, 1 planned) and new orders and diagnoses were provided by the medical director. All nutrition care plans audited by Minimum Data Set Nurse on 02/13/2024 with 5 residents whose registered dieticians' recommendations were not on care plans, dietary recommendations reviewed with providers and orders received per providers.

On 02/13/2024 at 6:05 PM, the Director of Nursing notified the physician of all 9 residents, notified the Institutional Specialized Needs Plan (ISNP) nurse practitioner of all residents (4) and hospice of all residents (1) with Nausea and Vomiting with new orders received from provider. 1 resident reviewed with new orders for chest x-ray due to cough, congestion, and yellow discharge from mouth and nose, 2 residents were ordered medications for reflux, 1 resident noted to be receiving antibiotics and has orders in place for anti-emetic medications, 1 resident reported abdominal pain and MD was notified and seen resident on 02/12/2024 with new orders for stool softener, 1 resident noted to have diarrhea and has been antibiotics new orders received for Zofran and anti-diarrheal, 1 resident noted to have weight loss and nausea and vomiting new orders received on 2/11/2024 to start Zofran and start peri-actin the family was not agreeable to start peri-actin and wanted to wait to speak to hospice on 02/14/2024, 2 residents did not report nausea to nurses at time of occurrence.

On 02/13/2024 at 6:59 PM, Social Services and Medical Records nurse interviewed residents with BIMS 10 or higher to ensure feeling of safe and are free of health concerns, no health or safety

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 692	Continued From page 103	F 692		

concern duringinterviews.

On 02/13/2024 at 8:30 PM, all Registered Dietician recommendations for last 90 days audited by Dietary Manager and Minimum Data Set Nurse with 5 residents whose registered dietician recommendations were not addressed. All Dietary recommendations reviewed with the Medical Director (5) and subsequent providers as appropriate Hospice (2 residents who have been on hospice services prior to survey entrance) and Institutional Special Needs Program nurse practitioner (1), new orders received from providers as appropriate.

On 02/13/2024 at 8:40 PM, All nutrition care plans audited by Minimum Data Set Nurse with 5 residents whose registered dieticians' recommendations were not on care plans, dietary recommendations reviewed with providers and orders received per providers and care plans updated.

On 02/13/2024 at 9:00 PM, all residents noted with weight loss were reviewed with the Medical Director, the Medical Director performed medication review on all residents with weight loss.

Ad Hoc QAPI was held on 02/13/2024 at 10:15 PM with the Medical Director via phone, Administrator, Director of Nursing, Social Services, Minimum Data Set Nurse, Life Connections Coordinator, Regional Nurse Consultant, Regional Director of Operations, Assistant Director of Nursing, Registered Nurse Supervisor, Dietary Manager, and Medical Records Nurse. The Minimum Data Set Nurse has been designated as the Quality Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 692	Continued From page 104	F 692		

Nurse with responsibility reviewing all audits, Performance Improvement Plans, Quality Measures, and actively participating in the Quality Assurance and Performance Improvement meetings. All areas of deficiencies were reviewed in Ad-Hoc Quality Assurance and Performance Improvement meeting. Medical Records nurse or Assistant Director of Nursing will be responsible for receiving Registered Dietician recommendations, reviewing with providers, entering orders, and progress notes. New processes for Medical Director to review facility weight losses each week on visit, Registered Dietitian recommendations to be reviewed weekly with the Interdisciplinary Team and the Medical Director by Friday, in the event Registered Dietician recommendations are not received, the medical director will be notified. The Dietary Manager will review the weight and vital sign exception report and present findings in the clinical meeting. The Director of Nursing will review weights and registered dietician recommendations. The Director of Nursing will review progress notes daily. The administrator will review the audit findings weekly. All results will be reviewed in Quality Assurance and Performance Improvement meetings.

On 02/13/2024 at 10:00 PM, One-on-one Inservice conducted with Administrator by the Regional Director of Operations for weights, care plans, Quality Assurance and Performance Improvement, Notifying Physicians, Registered Dietician Recommendations, Documentation, and Administration Processes. The Regional Nurse Consultant conducted one-on-one in-services with the Director of Nursing, Dietary Manager, Assistant Director of Nursing, Medical Records Nurse, and Minimum Data Set Nurse regarding

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 692	Continued From page 105	F 692		

weights, care plans, Quality Assurance and Performance Improvement, Notifying Physicians, Registered Dietician Recommendations, Documentation and Administration Processes. One-on-one in-service conducted with the Dietary Manager by the Administrator regarding Communication of Dietary Recommendations, Review of Recommendations, and reporting any identified areas of concerns with Dietary Recommendations. All nurses who provided care to resident #20 for the previous 3 weeks were provided One-on-one in-services regarding reporting changes of condition to provider, documentation, and following plan of care then were provided with a post-test to confirm understanding of one-on-one in-services.

As of 02/14/2024, the facility alleges compliance and all corrective action completed on 02/13/2024.

The Survey Agency (SA) validated the facility's Corrective Actions on 2/20/24:

The SA validated through record review that Resident #20 was ordered an anti-emetic for nausea/vomiting.

The SA validated through interview and record review that in-services were conducted for Abuse and neglect, documentation, provider notification, and change of condition. No staff can return to work until they have received in-services.

The SA validated through record review that all residents were interviewed and screened for symptoms of nausea and vomiting and the physician was notified of the findings with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 692	Continued From page 106 physician orders if appropriate. The SA validated through record review and staff interview that all residents were audited for weight loss and the Medical Director was updated. All nutrition care plans were audited and updated with dietary recommendations. The SA validated through record review that all residents with a Brief Interview for Mental Status (BIM's) of 10 or higher were interviewed to ensure feeling safe in their environment and free from health concerns. The SA validated through record review that all Registered Dietician (RD) recommendations were audited and addressed with the provider as appropriate. The SA validated the Medical Director reviewed the resident with weight loss and performed medication review. The SA validated through staff interview and record review on 2/20/24 that an Emergency Quality Assurance and Performance Improvement (QAPI) meeting was conducted on 2/13/24 with all members in attendance. The SA validated through record review and staff interview that one-on-one in-services were conducted on weights, care plans, Quality Assurance and Performance Improvement (QAPI), notifying physicians, reporting changes, Registered Dietician Recommendations, Documentation, and Administrative Processes. No staff can return to work until they have received in-services.	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 692	Continued From page 107 The SA validated that all corrective actions were completed on 2/13/24 and the IJ was removed as of 2/14/24.	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to follow the physicians order for continuous oxygen usage for one (1) of five (5) residents reviewed for continuous oxygen. Resident #15 Findings Include: Record review of the facility policy titled "Oxygen Administration" dated 8/25/14, revealed " ... Preparation: 1. Verify that there is a physician's order for this procedure... Documentation: After completing the oxygen setup or adjustment, the following information should be recorded in the resident's medical record: ... 7. How the resident tolerated the procedure. 8. If the resident refused the procedure, the reason(s) why and the intervention taken. Reporting: 1. Notify the supervisor if the resident refuses the procedure ..."	F 695	1. On 02/12/2024, the resident was encouraged to apply oxygen. On 02/12/24 the provider was notified by Assistant Director of Nurses of resident□s refusals to wear oxygen with orders to discontinue. 2. The alleged deficient practice has the potential to affect all residents on oxygen. 3. On 03/04/2024 licensed nurses in-serviced by Director of Nursing on ensuring physician orders are accurately transcribed and documented including notifying provider of refusals to meet professional standards of quality. On 02/13/2024 the Regional Nurse Consultant (RNC), in-serviced DON and ADON on ensuring physician orders are accurately transcribed and documented including	3/19/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 695	Continued From page 108 Record review of the "Order Summary Report" with active orders as of 2/12/24 for Resident #15 revealed an order dated 1/12/24, "O2 (oxygen) on continuously at 2ls (two liters) bnc. (by nasal cannula) every shift ..." An observation on 2/11/24 at 4:39 PM, of Resident #15 revealed her lying in bed with her eyes closed. She was unable to arouse to verbal stimuli. The resident's oxygen concentrator was observed by the bedside, with the oxygen cannula laying over the concentrator. An observation of Resident #15 on 2/12/24 at 2:35 PM, revealed the resident lying in bed. The resident was alert/verbal and confused. The oxygen cannula was observed laying over the oxygen concentrator at the bedside. An observation and interview with Licensed Practical Nurse (LPN) #1 on 2/12/24 at 2:43 PM, confirmed Resident #15 had not been wearing oxygen. LPN #1 explained she had applied the oxygen this morning, and the resident refused to keep it on. She revealed the resident had been refusing to wear the oxygen for a while. She confirmed she had not made the physician aware of the resident's refusal, and stated she should have. LPN #1 confirmed she should have documented that the resident refused, and instead she documented the oxygen as administered, which indicated the resident was using it. She stated she was unsure how long a resident must refuse a medication before the physician was contacted. An observation and interview with the Director of Nursing (DON) on 2/12/24 at 2:57 PM, confirmed she was aware Resident #15 had not been	F 695	notifying provider of refusals to meet professional standards of quality. 4. Starting 03/08/2024, the director of nursing will make weekly walking rounds of all residents with oxygen times 4 weeks, then bi-weekly times 4 weeks, then monthly times 2 months to ensure residents are receiving oxygen as ordered and that documentation of residents□ use of oxygen is correct. The Director of Nursing will take immediate corrective action if needed. The Director of Nursing will present the audit findings to Quality Assurance and Performance Improvement Committee monthly starting, 03/19/2024, 3 months then as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 695	Continued From page 109 wearing the oxygen that was ordered continuous. She revealed the resident had been refusing to wear the oxygen, and to her knowledge, none of the staff had reached out to the physician to make him aware. She confirmed the Medication Administration Record (MAR) should reflect the resident's refusal, and the facility should have reached out to the physician to notify. Record review of the February 2024, Medication Administration Record (MAR) revealed an order dated 1/12/24, "O2 (oxygen) on continuously at 2ls (two liters) bnc (by nasal cannula) every shift". The MAR was documented as oxygen having been administered 2/1/24 through 2/12/24, with no refusals documented. Record review of the "Progress Notes" for Resident #15 revealed there was not any documentation to support the refusal of oxygen. Record review of the "Admission Record" for Resident #15 revealed the facility admitted Resident #15 on 9/02/23 with diagnoses that included Unspecified dementia, Other seizures and Repeated falls.	F 695		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of	F 700		3/19/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 700	Continued From page 110 entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, family and staff interview, record review, and facility policy review, the facility failed to perform an accurate bed rail assessment, and failed to ensure that the bed rails did not pose a risk of injury for one (1) of 28 residents sampled. Resident #15 Findings Include: Record review of the facility policy titled "Bed Rails" dated 5/10/17 revealed "Policy Statement: It is the policy of this center to limit the use of bed rails and similar devices unless the benefit outweighs the risk. No rails of any type will be applied to a bed without prior assessment as to the appropriateness of the use and the device selected. This policy applies to the use of any type of rail attached to the bed, for any purpose. This includes side rails, half rails, quarter rails, split rails, assist rails, enabler bars ect., whether full or partial length. ... Before using a side rail for any reason, the staff shall inform the resident and or family/responsible party about any benefits or potential hazards associated with side rails ...	F 700	1. On 2/12/24, the bed rails were removed from Resident #15□s bed by the Maintenance Director. 2. The alleged deficient practice has the potential to affect all residents with side rails. 3. Starting 02/27/2024 and completed by 03/18/2024 by Director of Nurses, licensed staff will be in-serviced on ensuring residents are free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the residents medical symptoms. Starting 02/27/2024 and completed by 03/18/2024 by Director of Nurses, Licensed staff will be in-serviced that physical restraints or safety devices are only used to enable and/or promote functional independence of the resident after	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 700	Continued From page 111 Assessment and Documentation: A side rail assessment screen is completed on each resident upon admission, quarterly, and as needed.... A physician order will be obtained, a care plan implemented, and side rails will be checked for functionality and placement." Record review of the "Quarterly Evaluation" for Resident #15, dated 9/05/23, revealed under, "Summary Findings ... 2. Type of rail in use: Half rail 3. Rails in use: Bilateral ... 5. Bed rails are indicated and serve as an enabler to promote independence: yes..." During a telephone interview on 2/12/24 at 9:40 AM, with Resident #15's family member, revealed, the facility did not contact her regarding the application of bed rails. She stated that a bed rail consent had not been signed. During an observation on 2/12/24 at 2:30 PM, of Resident #15, revealed her lying in bed with her eyes open. She was alert, but confused. Three-quarter (¾) side rails were up on both sides of the bed and the resident was observed trying to get up, and scooted herself to the end of the opening of the bed rail, toward the footboard, and sat up on the end of the bed. During an interview and observation with the Director of Nursing (DON) on 2/12/24 at 2:50 PM, revealed she did not know why Resident #15 had the three-quarter (3/4) bed rails. She confirmed that the side rails kept the resident from getting up on her own and was a barrier for her safely getting up. She explained that the resident could possibly try to crawl over the top of the rails. The DON acknowledged there was a possibility of entrapment with the open style rails. She	F 700	consultation with a physical or occupational therapist, upon order of physician, and discussion with the resident□s responsible party. Starting 02/27/2024 and completed by 03/18/2024 by Director of Nurses, Licensed staff will be in-serviced on completing a signed consent from the family, a bed rail assessment, and a physicians order for the applied bed rails must be completed prior to applying side rails. Side rail evaluation form was modified on 3/12/24 to include a signature line for informed consent. Starting 02/27/2024, the Administrator and Director of Nurses reviewed siderail use and performed siderails evaluations for all residents, consents obtained for all applicable residents. Starting 03/13/2024, Maintenance Director will complete monthly inspection of side rails for proper functioning, proper measurements. 4. Starting 02/27/2024, the Director of Nurses (DON) will conduct walking rounds on five residents with side rails weekly times 4 weeks, bi-weekly times 4 weeks and monthly times 2 months. The Maintenance Director will complete monthly inspection of the side rails for proper functioning and proper measurements. The Maintenance Director and Director of Nursing will report results of the audit to Quality Assurance Performance Improvement Committee (QAPI) monthly,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 700	Continued From page 112 revealed that she had no idea how long the rails had been on the bed, and the facility had not performed an assessment that would indicate a need for them. She explained that to her knowledge, the family had not signed a consent. An interview with the Minimum Data Set (MDS) Nurse on 2/14/24 at 5:19 PM, revealed she had never seen the three-quarter (3/4) rails on Resident #15's bed. She explained when she did the resident's last Minimum Data Set (MDS) assessment in November 2023, the resident had the ½ (one-half) side rails. The MDS Nurse stated the resident had a room change and stated those three-quarter (3/4) rails must have been on the bed in that room. Record review of the "Order Summary Report" for Resident #15 revealed an order dated 9/27/23, "1/2 (one-half) Side Rails X (times) 2 (two) as an enabler..." Record review of the "Admission Record" for Resident #15 revealed the facility admitted Resident #15 on 9/02/23 with diagnoses that included Unspecified dementia, Other seizures and Repeated falls.	F 700	starting 03/19/2024, for 3 months and as needed for review/revision.	
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care	F 726		3/19/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 726	Continued From page 113 and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review and facility policy review, the facility failed to ensure an employee maintained a current Certified Nurse Aide (CNA) certification for one (1) of twenty-seven Certified Nurse Aide certifications reviewed. CNA #5 Findings include: Review of the facility policy titled; "Registry of Nurse Aides" dated June 2000 revealed It is the policy of this facility that certified nurse aides licenses be verified through the registry of nurse	F 726	1. Certified Nursing Assistant # 5 removed from payroll system. The Business Office Manager audited all licenses and took corrective actions as necessary on 02/20/2024. 2. This alleged deficient practice has the potential to affect all residents. 3. On 02/27/2024, the Regional Director of Operations in-serviced the Administrator and the Business Office Manager on ensuring that only current licensed and certified staff are hired into the facility, as well as	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 726	Continued From page 114 aides." Record review of the Mississippi Nurse Aide Registry revealed CNA # 5's certification expired on 11/30/2023. An interview on 02/15/24 at 11:55 AM, the Assistant Director of Nurses (ADON) revealed CNA #5 was hired on 11/3/23 and confirmed the CNA's certification expiration date of 11/30/23 was overlooked. The ADON stated she tries to look at each CNA's certification at least every 6 months to make sure they aren't expiring. An interview on 02/15/24 at 12:05 PM, the Director of Nurses (DON) revealed CNA #5's last day of employment was on 2/9/24 and she was terminated for unrelated issues. She revealed she wasn't aware that CNA #5's certification ended on 11/30/23 and confirmed that CNA #5 had worked through 2/9/24 with an expired certification. An interview on 02/15/24 at 12:15 PM, the Administrator (ADM) revealed the Business Office Manager verifies and prints the CNA certifications upon hire as part of the onboarding process. She revealed it should have been flagged that CNA #5's certification was going to be out at the end of the month since she had just been hired on 11/3/23 and CNA #5 "should have been told to renew her certification." The ADM stated "this was an oversight on our part."	F 726	ensuring licensed and certified staff are reviewed to ensure staff remain up to date and current with their licensed or certified status. 4. The Business Office Manager and Administrator will review all licenses weekly times 4, bi-weekly times 4, then monthly thereafter to ensure that all licenses are up to date and current. The Business Office Manager and the administrator will take immediate corrective action as needed. The Business Office Manager and Administrator will report audit findings to Quality Assurance and Performance Improvement Committee on 03/19/2024, for 3 months, and as needed for review and revision	
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its-	F 759		3/19/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 759	Continued From page 115 §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and facility policy review, the facility failed to ensure the medication error rate was five (5) percent (%) or less for two (2) of twenty-six medication opportunities. Findings Include: Review of the facility's "Med Error Rate" following reconciliation indicated the medication error rate was 7.69% (percent). Record review of the facility policy review titled "Medication Administration-General Guidelines" with a revision date of 8/25/14 revealed "PROCEDURE: ... 2. Administration: ... b. Medications are administered in accordance with written orders of the attending physician... 3. Documentation: a. The individual who administers the medication dose records the administration on the resident's MAR (Medication Administration Record) directly after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered and documented ..." An observation during medication pass with Licensed Practical Nurse (LPN) #3 on 2/14/24 at 7:45 AM, revealed she prepared Resident #211's medications while reading the Medication Administration Record (MAR), and entered the resident's room and administered the following medications: Diclofenac Sodium External Gel 1% ([pain), Ascorbic Acid 500 MG (milligrams)	F 759	1. On 02/13/2024, Medical Director was notified of medication errors on resident #211 with new orders to administer apixaban at next scheduled dose and #20. Nurse #3 was removed from medication cart and sent home. On 3/10/2024, missed entries for Resident #1, #2, #3, #4, #5, #9 were noted on the Medication Administration and Treatment Administration Record. MD was notified with no new orders. 2. This alleged deficient practice has the potential to affect all residents. 3. Nurse #3 completed documentation in-service, hand hygiene check-offs, and medication administration in-service and check-offs conducted by the Director of Nurses prior to returning to work on 02/14/2024. On 02/14/2024, the Assistant Director of Nursing supervised Medication Administration for Nurse #3 to ensure no medication errors occurred and infection control standards were met. Starting on 02/13/2024, nurses were in-serviced by Assistant Director of Nurses and Director of Nurses on medication administration, refusals of medications, and notifying the physician. Starting on 02/24/2024, nurses were required to complete medication administration check-offs with the Director of Nursing or Assistant Director of Nursing. Pharmacy Consultant to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 759	Continued From page 116 (supplement), Gabapentin 300 MG (pain), Multivitamin (supplement), Metoprolol Tartrate 12.5 MG (blood pressure), Propafenone 150 MG (heart rhythm), Zinc 220 MG (supplement), Tramadol 50 MG (pain), and Juven oral packet (supplement). Record review of the Medication Administration Record (MAR) after reconciliation of the medication observation revealed the medication Apixaban 5 MG (blood thinner) was not administered to Resident #211 by LPN #3. Record review of Resident #211's MAR for February 2024, revealed an order dated 2/2/24, "Apixaban Oral Tablet 5 MG Give 1 (one) tablet by mouth two times a day related to Paroxysmal Atrial Fibrillation..." An interview with LPN #3 on 2/14/24 at 8:40 AM, revealed she thought she had administered the medication Apixaban 5 MG to Resident #211. She revealed she read the MAR, popped the medication out of the blister pack into the med cup and clicked the prepared button. LPN #3 opened the medication cart to pull out the medication card and revealed that the medication was in the cart. She stated, "I somehow missed it." She confirmed she should have read the MAR and ensured the medication was in the med cup before marking the medication as prepared. Record review of Resident #211's Admission Record revealed the resident was admitted to the facility on 2/03/24 with medical diagnoses that included Paroxysmal Atrial Fibrillation, Type 2 Diabetes Mellitus with Hyperglycemia, and Essential (Primary) Hypertension.	F 759	conducted medication administration observation during visit on 03/15/2024 with 2 nurses on shift. Licensed Nurses will complete medication administration check offs annually and as needed beginning 02/24/2024. Starting 03/14/2024, licensed nurses were educated on medication errors. Starting 03/14/2024, medication administration records and treatment administration records were audited for missed documentation starting 3/1/2024 to present. 03/10/2024, medical provider was notified of missed medications or treatments. 4. Starting 02/29/2024, the Assistant Director of Nursing will observe medication administration weekly for 4 weeks, bi-weekly x 4 weeks, then monthly x 2 months to ensure no medication errors occur alternating staff, unit, and shift observed. The Assistant Director of Nursing will take immediate corrective action as needed. Starting 3/14/2024, The Director of Nursing will review Medication Administration Record and Treatment Administration Record 5 days per week for missed documentation for 4 weeks, then weekly for 4 weeks, then monthly for 2 months. The Director of Nursing will take immediate corrective action as needed. The Director of Nursing and Assistant Director of Nursing will report audit findings to Quality Assurance and Performance Improvement Committee starting on 03/19/2024 for 3 months and as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 759	Continued From page 117 Resident #20 An observation on 2/14/24 at 8:20 AM, of medication pass with LPN #3 revealed that she entered Resident #20's room and administered Brimonidine 0.1% eye drops two (2) drops to both eyes. Record review of the MAR for Resident #20 revealed an order dated 12/13/23, "Brimonidine Tartrate Solution 0.1 % (percent) Instill 1 (one) drop in both eyes two times a day for glaucoma..." Record review of the MAR after reconciliation of the medication observation revealed the medication Brimonidine 0.1.% (lowers pressure in the eye) should have been administered as one (1) drop to both eyes. An interview with LPN #3 on 2/14/24 at 8:40 AM, confirmed that she gave Resident #20 two (2) drops in each eye instead of the ordered (1) drop. She revealed this was a medication error, and they would have to let the physician know and revealed that she misread the order. Record review of the "Transfer/Discharge Report" revealed the facility admitted Resident #20 on 1/24/22 with medical diagnoses that included Primary open-angled glaucoma and Alzheimer's disease.	F 759		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors.	F 760		3/19/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 760	Continued From page 118 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure a resident was free of any significant medication errors for one (1) of eleven medication administration observations. Resident #211 Findings Include: Record review of the facility policy review titled "Medication Administration - General Guidelines" with a revision date of 8/25/14 revealed" ...PROCEDURE: ...Documentation: a. The individual who administers the medication dose records the administration on the resident's MAR (Medication Administration Record) directly after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered and documented..." On 2/14/24 at 7:45 AM, during a med pass observation and interview, with Licensed Practical Nurse (LPN) #3 revealed, she prepared Resident #211's medications while reading the MAR and entered the resident's room and administered the following medications: Diclofenac Sodium External Gel 1% (pain), Ascorbic Acid 500 MG (milligrams) (supplement), Gabapentin 300 MG (pain), Multivitamin (supplement), Metoprolol Tartrate 12.5 MG (blood pressure), Propafenone 150 MG (heart rhythm), Zinc 220 MG (supplement), Tramadol 50 MG (pain), and Juven oral packet (supplement). When asked about Apixaban 5 MG, LPN #3 opened the medication cart to pull out the medication card and revealed	F 760	1. On 02/13/2024, Medical Director was notified of medication errors on resident #211 with new orders to administer apixaban at next scheduled dose and #20. Nurse #3 was removed from medication cart and sent home. On 3/10/2024, missed entries for Resident #1, #2, #3, #4, #5, #9 were noted on the Medication Administration and Treatment Administration Record. MD was notified with no new orders. 2. This alleged deficient practice has the potential to affect all residents. 3. Nurse #3 completed documentation in-service, hand hygiene check-offs, and medication administration in-service and check-offs conducted by the Director of Nurses prior to returning to work on 02/14/2024. On 02/14/2024, the Assistant Director of Nursing supervised Medication Administration for Nurse #3 to ensure no medication errors occurred and infection control standards were met. Starting on 02/13/2024, nurses were in-serviced by Assistant Director of Nurses and Director of Nurses on medication administration, refusals of medications, and notifying the physician. Starting on 02/24/2024, nurses were required to complete medication administration check-offs with the Director of Nursing or Assistant Director of Nursing. Pharmacy Consultant to conducted medication administration observation	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 760	Continued From page 119 that the medication was in the cart. She stated, "I somehow missed it." She confirmed that she should have read the MAR and ensured the medication was in the med cup before marking the medication as prepared. Record review of the MAR after reconciliation of the medication observation, revealed the medication Apixaban 5 MG (milligrams)(blood thinner) was not administered to Resident #211. Record review of Resident #211's MAR for February 2024, revealed an order dated 2/2/24, "Apixaban Oral Tablet 5 MG Give 1 (one) tablet by mouth two times a day related to Paroxysmal Atrial Fibrillation..." On 2/15/24 at 8:20 AM, during an interview with the Regional Nurse Consultant (RNC) revealed the medication Apixaban (blood thinner) was considered a high-risk medication and a missed dose could place Resident #211's health at risk. Record review of the "Admission Record" revealed the facility admitted Resident #211 to the facility on 2/03/24 with medical diagnoses that included Paroxysmal atrial fibrillation, Type 2 diabetes mellitus with hyperglycemia, and Essential (primary) hypertension.	F 760	during visit on 03/15/2024 with 2 nurses on shift. Licensed Nurses will complete medication administration check offs annually and as needed beginning 02/24/2024. Starting 03/14/2024 and completed on 03/19/2024, licensed nurses were educated on medication errors by the Director of Nursing. Starting 03/14/2024, medication administration records and treatment administration records were audited for missed documentation starting 3/1/2024 to present by the Assistant Director of Nursing. 03/10/2024, medical provider was notified of missed medications or treatments. 4. Starting 02/29/2024, the Assistant Director of Nursing will observe medication administration weekly for 4 weeks, bi-weekly x 4 weeks, then monthly x 2 months to ensure no medication errors occur alternating staff, unit, and shift observed. The Assistant Director of Nursing will take immediate corrective action as needed. Starting 3/14/2024, The Director of Nursing will review Medication Administration Record and Treatment Administration Record 5 days per week for missed documentation for 4 weeks, then weekly for 4 weeks, then monthly for 2 months. The Director of Nursing will take immediate corrective action as needed. The Director of Nursing and Assistant Director of Nursing will report audit findings to Quality Assurance and Performance Improvement Committee on starting on 03/19/2024 for 3 months and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 760	Continued From page 120	F 760	as needed.	
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its	F 801		3/19/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 801	Continued From page 121	F 801		

successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section.
(iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law.

§483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services.
(i) The director of food and nutrition services must at a minimum meet one of the following qualifications-
(A) A certified dietary manager; or
(B) A certified food service manager; or
(C) Has similar national certification for food service management and safety from a national certifying body; or
D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or
(E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and
(ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 801	Continued From page 122 managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to ensure qualifying certifications were held by the Dietary Manager during ten (10) of 10 days of survey. Findings include: Record review of facility policy titled "Dietary Manager", dated 12/21/17, revealed, " ...Procedure: 1. The Dietary Manager is a qualified dietetic service supervisor licensed by this state in accordance with the American Dietetic Association's rules, regulations, and guidelines; ..." During an interview on 2/13/24 at 10:45 AM, the Dietary Manager revealed she had worked as Dietary Manager at the facility for approximately six months and stated she was not certified and was not enrolled in a program to become certified. She revealed corporate did not have a Certified Dietary Manager come into facility to assist the facility's dietary staff. She revealed the Registered Dietician (RD) met remotely for consults and in the time she had worked at the facility, she had not had an in-person visit with the RD. An interview with the Administrator on 2/14/24 at 4:45 PM, revealed she was unaware a certification for the Dietary Manager position was required and she thought the facility had one year from the hire date for the Dietary Manager to	F 801	1. On 02/23/2024, Dietary Manager registered and paid for a course of study in Nutrition and Foodservice Professional Training through the University of North Dakota. The course is preparation for the national Certifying Board for Dietary Managers Credentialing Exam. 2. The alleged deficient practice has the potential to affect all residents. 3. On 02/23/2024, the Regional Director of Operations in-serviced the Administrator and Dietary Manager on the requirement to meet the qualifications as listed in 483.60(a)(2). The Registered Dietician will oversee the Dietary Manager Duties through routine visits and calls. The target completion date for the Dietary Manager is 12/15/2024. 4. The Administrator will meet with Dietary Manager weekly starting 03/05/2024 to review progress toward completion of the Nutrition and Foodservice Professional Training Course until the course is completed. Any issues will be immediately addressed. The Administrator will report results of the progress to Quality Assurance Performance Improvement Committee (QAPI) on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 801	Continued From page 123 obtain certification and the Dietary Manager's hire date was 6/19/23. She confirmed the facility's Dietary Manager was not certified or enrolled in a certification program and there was no corporate staff member that served as a consultant for the Dietary Manager.	F 801	03/19/2024, for 9 months or until course completed and as needed for review/revision.	
F 835 SS=K	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, record review, and job description review, the facility failed to be administered in a manner that ensured residents with significant weight loss would get the necessary nutritional support and services to ensure their well-being for two (2) of three (3) residents sampled for abuse/neglect as evidenced by: Resident #13 and Resident #20 1) failed to recognize, evaluate, and address a resident's nutritional needs, which resulted in an unintended significant weight loss of 6.92% (percent) in one (1) month, which further led to a significant weight loss of 17.52% (percent) in four (4) months. Resident #13. The facility's failure to consult a Registered Dietician (RD), notify the attending physician of a significant change in condition, and act upon the residents' weight loss, placed the resident, and all other residents residing in the facility at risk for serious harm,	F 835	1. On 02/11/2024, antiemetic medication was ordered for resident #20. On 02/14/2024, resident #20 was ordered appetite stimulant. On 02/14/2024, Resident #20 was admitted to hospice services. On 02/14/2024, Resident #20 received an order for a laxative and was administered a laxative and abdominal x-ray. On 02/15/2024, resident #20 still had no results from laxative, provider was notified, and order received for enema with results noted. On 2/15/2024, resident #13 was ordered fortified cereal and fortified mashed potatoes. 2. All residents in the facility have the potential to be affected by the alleged negligent practices. 3. Starting 02/13/2024, licensed nurses in-serviced on notifying provider of changes in condition with posttest to confirm understanding. One-on-One	3/19/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 835	Continued From page 124 serious injury, serious impairment, and possibly death. 2) failed to identify and address a resident at risk for malnutrition due to prolonged nausea and vomiting, and failure to identify a decrease in food intake due to pain and nausea resulted in an unintended significant weight loss of 40.5 pounds in six (6) months. Resident #20. The facility's failure to implement a Registered Dietician (RD) recommendation, notify the attending physician of a significant change in condition, and address the residents' prolonged symptoms of nausea and vomiting, and decreased food intake placed the resident and all other residents residing in the facility at risk for serious harm, serious injury, serious impairment, and possibly death. The facility's neglect also resulted in a functional decline for Resident #20, which possibly resulted in the resident's admission to hospice services on 2/14/24. The State Agency (SA) identified an Immediate Jeopardy (IJ) that began on 11/02/23 when the facility failed to recognize, evaluate, and address Resident #13's nutritional needs. The IJ existed at: 42 CFR §483.70 Administration - F835-Scope/Severity "K" The facility Administrator was notified of the IJ on 2/13/24 at 4:30 PM and provided the IJ Template. The facility provided an acceptable Removal Plan on 2/14/24, in which they alleged all corrective actions to remove the IJ were completed on 2/13/24 and the IJ removed on 2/14/24.	F 835	in-services with the Director of Nursing, Dietary Manager, Assistant Director of Nursing, Medical Records Nurse, and Minimum Data Set Nurse regarding weights, care plans, notifying physician, Quality Assurance and Performance Improvement meetings, Registered Dietitian Recommendations, Documentation, and Administration were conducted by the Regional Nurse Consultant. On 02/13/2024, the Regional Director of Operations conducted and One-on-One inservice with the Administrator regarding weights, care plans, notifying physician Starting 03/08/2024, Rehab Director to in-service therapy staff to notify nurse of changes in resident conditions and concerns promptly. On 03/07/24, a new registered dietician began covering facility. Starting 02/13/2024, all staff will be in-serviced on abuse and neglect and will be provided with a posttest to confirm understanding. On, 03/08/2024, all residents receiving an opioid pain medication were assessed for side effects with provider notification and orders as needed. Starting 03/08/2024, licensed staff were educated regarding the side effects of opioid medications, observation orders, and signs and symptoms to report to the provider. 4. Regional Director of Operations will conduct weekly visits starting 02/13/2024 for four weeks then monthly for 3 months to conduct facility audits including Quality Assurance and Performance Improvement meeting minutes, At-Risk meetings including weights and wounds, all open Performance Improvement Plans,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 835	Continued From page 125 The SA validated the Removal Plan on 2/20/24 and determined the IJ was removed on 2/14/24. Therefore, the scope and severity for 42 CFR §483.70 Administration - F835 was lowered from a "K" to an "E" while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings Include: Review of the Job Description for the Nursing Home Administrator (NHA) with a revision date of 8/10/27 revealed, "Summary: As Nursing Home Administrator, you will be responsible for the overall operations, leadership, management and success of the facility in accordance with resident/employee needs, government regulations, and company policy. Responsible for ... quality assurance, regulatory management, ... and resident care...Essential Duties And Responsibilities: ... Direct and coordinate medical, nursing and administrative staffs and services. ... Conduct regular rounds to monitor delivery of nursing care and operation of support departments. ... Ensure consultants and other support resources are appropriately utilized. " Review of the Job Description for the Director of Nursing (DON) with a revision date of 8/10/17 revealed, "Summary: To manage overall operation of the Nursing Services Department in accordance with Company Policies, standards of nursing practices and governmental regulations so as to maintain excellent care of all the Residents' and employee's needs...Essential Duties And Responsibilities: Work with the Administrator, Consultants, and facility staff in	F 835	and compliance with plan of correction. Regional Director of Operations will attend Quality Assurance and Performance Improvement meetings starting 03/19/2024 and then for 3 months. The Regional Director of Operations will report all audit findings to the Quality Assurance and Performance Improvement Meetings monthly for 4 months, starting on 03/19/2024, then as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 835	Continued From page 126	F 835		

planning all aspects of nursing services to include interface with other disciplines and departments. ... Conduct regular rounds to review care. Assess resident's physical and psychosocial status. Monitor care activities and documentation to ensure the delivery of nursing care according to the physician's order, care plans, and established standards and facility policies. ... Follow and ensures compliance with State, Federal, and company QAPI (Quality Assurance and Performance Improvement) standards. Follow and ensures medication administration is conducted in accordance with nursing standards and facility policies..."

Review of the Job Description for the Assistant Director of Nursing (ADON) with a revision date of 8/10/17 revealed, "Summary: ... Also assist the Director of Nursing in managing overall operations of the Nursing Services Department in accordance with Company policies, standards of nursing practices and government regulations so as to maintain excellent care of all the Residents' and employee's needs....Essential Duties And Responsibilities: ... Responsible for overseeing nursing services in the absence of the Director of Nursing. ... Assists in conducting regular rounds to monitor resident activity and ensure resident quality of care. Assess resident's physical and psychosocial status. ... Personally participates in the assessment and delivery of care. ... Follow and ensures compliance with State, Federal, and Company QAPI standards." ...

Record review of the facility policy titled "Dietician" with a review date of 7/24/23 revealed, "Policy Interpretation and Implementation: 1. A qualified dietician or other clinically qualified nutrition professional will help oversee food and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 835	Continued From page 127	F 835		

nutrition services provided to the residents. ... 9. Our facility's dietician is responsible for, but not necessarily limited to: a. assessing nutritional needs of residents; ... f. participating in quality assurance and performance improvement (QAPI) when food and nutrition services are involved... "

Resident #20

Observation and interview with Resident #20 on 2/11/24 at 3:19 PM, revealed her lying in a fetal position at the foot of the bed with garbage can located on the floor beside the resident. The resident stated she was sick to her stomach and had a washcloth in her hand and was wiping her face. The resident's color was pale, lips were dry, and she was thin in appearance.

Interview with the DON on 2/11/24 at 3:55 PM, revealed Resident #20's condition had declined over the past couple of months. She explained that the resident had a significant decline after she fell in December 2023, and received a fracture of the T-12 vertebrae and had to be placed on strong pain medications. She stated, to her knowledge, the resident had not experienced any nausea and vomiting until yesterday when the Survey Agency brought it to her attention. She stated none of the staff had reported it to her and that she should be aware of what was happening with the resident. She revealed she was aware that the resident was not eating or drinking and had been refusing meals.

An interview with the Assistant Director of Nursing (ADON) on 2/11/24 at 6:18 PM, revealed she had not been informed by the staff that Resident #20 had been experiencing nausea and vomiting and stated she was unsure how long the resident had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 835	Continued From page 128	F 835		

been sick.

Observation of Resident #20 on 2/12/24 at 8:29 AM, revealed her lying on her right side in bed. The garbage can was located on the floor, close by the resident. The breakfast tray was located on the bedside table untouched. Certified Nurse Aid CNA #2 entered the resident's room and stated the resident refused to eat or drink due to nausea. CNA #2 removed the tray cover, and the resident began retching and vomited a small amount of clear substance. The resident was weak, pale, and her lips were dry.

Interview with CNA #2 on 2/12/24 at 8:35 AM, revealed she had worked at the facility for three (3) weeks and that the resident had been refusing to eat or drink since then. She explained that the resident had been nauseated, dry heaving, and vomiting for the three (3) weeks since she had been employed, and she had reported it to the medication nurse every day that she worked.

Interview with CNA #1 on 2/15/24 at 8:35 AM revealed Resident #20 refused breakfast due to nausea and she had notified the nurse each time that she witnessed the resident with nausea and vomiting or refusing to eat and drink.

Record review of Resident #20's "Progress Notes" from 11/01/23 through 2/11/24, revealed there was not any documentation that the resident had nausea and vomiting or that she refused meals.

Record review of the "Occupational Therapy Progress Notes" dated 2/01/24 revealed, "Patient refused: pt (patient) is refusing to eat and has poor appetite. pt (patient) c/o (complains of)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 835	Continued From page 129	F 835		

nausea almost every day, but is not eating even with max encouragement and assist from therapist." ... Also revealed under, "Assessment and Summary of Skilled Services: ... therapist encouraging pt (patient) daily to eat and providing assist, but pt (patient) refuses to eat and c/o (complains of) nausea." ...

Record review of the "Order Summary Report" for Resident #20 revealed an order dated 2/11/24 at 1827 (6:27 PM), "Ondansetron HCL (Hydrochloride) (Zofran) Tablet 4 (four) MG (milligrams) Give 1 (one) tablet by mouth every 6 (six) hours as needed for Nausea and Vomiting" ...

Record review of Resident #20's January and February 2024 "Medication Admission Record" (MAR) revealed, there was not a physician's order for nausea/vomiting medication before the new order for Zofran started on 2/11/24, which indicated the resident's symptoms of prolonged nausea and vomiting were left untreated.

Record review of the "Meal Intake Documentation Report" completed by the Certified Nurse Aides (CNAs) revealed, Resident #20 refused eighteen (18) meals from 12/18/23 through 12/31/23. She refused thirty-one (31) meals in the month of January 2024, with a total of thirty-nine (39) meals consumed at 0-25% (percent), and she refused sixteen (16) meals from 2/01/24 through 2/11/24, with a total of fourteen (14) meals consumed at 0-25% (percent).

Record review of Resident #20's weights revealed a significant weight loss of 13.9% (percent) in one (1) month, 21.6% (percent) in three (3) months, and 26.2% (percent) in six (6)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 835	Continued From page 130	F 835		

months.

Record review of the "Dietary Recommendations" dated 12/27/23, for Resident #20 revealed the RD (Registered Dietician) recommended, "Med Pass 2 oz (ounces) BID (twice daily), weekly weights x (times) 4 (four) weeks, and add Fortified Pudding BID (twice daily) at lunch and dinner" ...

Record review of the "Consultant Registered Dietician (RD) Note" dated 1/5/24, for Resident #20 revealed, "Resident w/(with) significant wt (weight) loss x (times) 1 (one) mo (month) (-9%) and x (times) 6 (six) mo (months) (13.7%) (percent). Po (by mouth) intake likely not meeting nutritional needs. Resident is at risk for skin breakdown and wt (weight) loss d/t (due to) decreased appetite ... NO N/V/c/D (nausea, vomiting, complaints of diarrhea) documented." ... Also revealed under REC (recommendations): "Resident may benefit from an appetite stimulant, please document % (percentage) of supplement consumed daily, add fortified pudding BID (twice daily) at lunch and dinner, weekly weights x (times) 4 (four) weeks to assure stable weight" ...

Record review of the "Consultant Registered Dietician (RD) Note) dated 2/10/24, for Resident #20 revealed, "Resident w/(with) significant wt (weight) loss x times 1 (one) mo (month), x (times) 3 (three) mo (months) and x (times) 6 (six) mo (months) ... consuming <25% w/(with) refusals of meals ... Po (by mouth) intake likely not meeting nutritional needs ... NO N/V/c/D (nausea, vomiting, complaints of diarrhea) documented." ... Also revealed under REC (recommendations): "Resident may benefit from an appetite stimulant, please document % of supplement consumed daily, weekly weights x 4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 835	Continued From page 131	F 835		

weeks to assure stable weight, if po (by mouth) intake and wt (weight) status does not improve, resident may benefit from an alternate means of nutrition support."

Record review of the "Order Summary Report" for Resident #20 revealed there was not a physician's order for fortified pudding at lunch and supper or a medication to stimulate appetite per Registered Dietician (RD) recommendations.

Telephone interview with Medical Director on 2/12/24 at 6:05 PM, revealed the staff had contacted him last night regarding Resident #20 having nausea and vomiting, and he had ordered Zofran as needed. He confirmed that the staff had not contacted him or made him aware of the residents' decline in condition or her refusal to eat or drink. He stated that he was not notified of her significant weight loss (40.5 pounds in 6 months) or the Registered Dietician (RD) recommendations. He confirmed Resident #20's current condition was serious and stated what you have relayed screamed neglect.

Record review of Resident #20's Physician Nursing Home Visit dated 1/26/24 revealed, "No concerns reported by the nursing staff ...." The physician progress note did not identify any documentation to support the resident's nausea and vomiting or weight loss.

Interview with Licensed Practical Nurse (LPN) #2 on 2/13/24 at 7:45 AM, revealed Resident #20 was not drinking the med pass supplement, and was refusing meals. She stated that the resident had been refusing meals for several weeks. She revealed that the resident's family was highly involved with her care, and the resident would

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 835	Continued From page 132	F 835		

report nausea to them, and they would come and notify her.

Interview with the Dietary Manager (DM) on 2/13/24 at 8:13 AM, revealed that the RD was consulted on Resident #20 in January 2024, but confirmed that she had not seen any RD recommendations. She stated that the resident had never received fortified pudding, and to her knowledge, had never started on an appetite stimulate. She explained that the facility had trouble getting the RD recommendations. The DM stated she just realized last week on Friday 2/9/24 that the RD recommendations were going to her spam email. She revealed that she tried to open the email and the email read it was quarantined. She revealed that she told the DON that she was not receiving anything from the RD, and she thought the DON had texted her. She revealed that the administrator had been going into all the residents' progress notes and printing out the recommendations to make sure they were being implemented. She confirmed that lack of implementation of the RD recommendations could cause the resident to have weight loss and malnourishment.

Telephone interview with the Registered Dietician (RD) on 2/13/24 at 9:56 AM, the RD stated she was notified in late December that Resident #20 needed to be seen due to a significant change. She revealed that she recommended med pass 2 ounces twice daily as a supplement, weekly weights and fortified pudding added with lunch and dinner. She revealed that she also did a consultation on Resident #20 on 1/5/24 and 2/10/24 and recommended that the resident would benefit from an appetite stimulant. She explained that she emailed all her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 835	Continued From page 133	F 835		

recommendations to the ADM, DON, DM, and the Regional Nursing Consultant (RNC). She explained that she marked on the recommendations if the resident's physician needed to be contacted for a physician order. She stated that she had not been contacted by anyone from the facility reporting that they had not received Resident #20's dietary recommendations.

Interview with the DON on 2/13/24 at 10:38 AM. she confirmed after reviewing the progress notes, she observed there was no documentation to support Resident #20's decline, nausea, and vomiting or food refusal. She confirmed that the facility should have notified the physician immediately when the decline came about, and verbalized that was a failure on their part. The DON stated that the facility did not reach out to the physician to inquire about drawing labs or starting any Intravenous fluids (IV) throughout these months of the resident refusing to eat or drink. She stated that she did report the weight loss to the physician while he was inside the facility. She stated, "I do not recall the date or month I notified him." She confirmed that she did not have documentation to support her notification. She stated the RD recommendations were not implemented because the facility was not receiving any of them, and the DM determined that the emails were going to her junk folder. She explained that the Administrator was going into the resident notes and printing them out to ensure they were all implemented. She revealed she was unsure if an audit was conducted to ensure all the recommendations were implemented. The DON stated that the RD would also add notes into the Electronic Medical Record (EMR) and would not tell anyone. She

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 835	Continued From page 134	F 835		

revealed that she had texted the RD to tell her that the recommendations were not received, and the RD would reply that she would resend them. The DON stated she had never received any emails from the RD, and confirmed that she had not gone into her junk email to search and see if they came to her that way. The DON stated, "I have over 700 junk emails and I do not have time to do that."

Interview with the Administrator (ADM) on 2/13/24 at 2:10 PM, revealed that the facility usually communicates with the current RD through email or text messages. The ADM stated the last RD recommendation she had received by email was in August 2023 and that the Dietary Manager (DM) had received some, but they went to her spam folder encrypted. She explained that she had not reached out to the RD herself to follow up and confirmed that the facility had not started an audit and stated they tried to go over the recommendations in the High-Risk meetings. She stated that Resident #20 had been discussed in January 2024 during a PAR (patients at risk) meeting. The ADM confirmed that the Dietary Recommendations for Resident #20 had not been implemented and that the facility failed to document the significant changes that occurred in the resident's condition. She stated, "I know the documentations not there." She revealed that she was told the DON had reached out to the physician and stated, "It looks bad on our part."

Record review of Resident #20's Order Summary Report revealed an order dated 1/02/24, "Norco Oral Tablet 7.5 -325 MG (milligrams) (Hydrocodone-Acetaminophen) Give 7.5 mg (milligrams) by mouth every 6 (six) hours related to Pain ..."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 835	Continued From page 135 Record review of Resident #20's Order Summary Report revealed an order dated 12/13/23, "Tramadol HCL (Hydrochloride) Tablet 50 MG (milligrams) Give 1 tablet by mouth every 12 (twelve) hours as needed for pain. Also revealed an order dated 12/13/23, "Tramadol HCL (Hydrochloride)Tablet 50 MG (milligrams) Give 2 (two) tablets by mouth every 12 (twelve) hours as needed for pain ..." Record review of Resident #20's Pain Care Plan revealed under, "Interventions/Tasks: ... Observe/document for side effects of pain medication. Observe for constipation; ... nausea; vomiting; ... Report occurrences to the physician." ... Record review of Resident #20's BM (bowel movement) Report dated 1/29/24 through 2/13/24 revealed one (1) medium BM documented on 2/04/24. All other days documented as "None" or "Not Applicable" ... Interview with the Assistant Director of Nursing (ADON) on 2/13/24 at 5:10 PM, revealed the aides were responsible for documenting the bowel movements every shift. She revealed if a resident did not have a bowel movement in 3 days, it will trigger the charting system dashboard and will alert the DON. She revealed that the dashboard was checked every morning by the DON after the daily stand-up meeting to identify which residents had not had a BM. She explained that the DON would then check with the nurses and the aides on the floor to identify if a resident had a BM, and maybe it was not documented. If a resident had not had a BM, a process was followed through with pulling a standing order for	F 835		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 835	Continued From page 136	F 835		

a laxative. She revealed that Resident #20's BM report was not firing to the dashboard to alert the staff of no BM.

Interview with the DON on 2/13/24 at 5:36 PM, confirmed the facility did not have a monitoring tool in place for the residents receiving high doses of opioid pain medication to monitor for the common side effects of constipation, nausea, and vomiting. She revealed that Resident #20's BM Report was not firing to the charting system database to alert the staff of no BM. She confirmed that Resident #20 had not had a documented BM since 2/4/24. She explained that the resident was incontinent, so if she did have a bowel movement, the staff would have known. She stated that the physician had not been notified at this point. She revealed that she was going to tell Resident #20's nurse to administer a laxative, and she would follow up with the resident in the morning.

Interview with the Director of Nursing (DON) on 2/14/34 at 9:20 AM, revealed she was unsure if Resident #20 had a bowel movement (BM) overnight. She revealed that with everything going on in the facility yesterday, she forgot to notify the nurse caring for the resident last night that she needed a laxative. She explained if a laxative had been administered it would be documented on the Medication Administration Record (MAR) and it was not. She stated," I will get someone to do it now."

Interview with the Director of Nursing (DON) on 2/14/24 at 2:55 PM, revealed she had not notified the nurse on the floor caring for Resident #20 to give her a laxative and confirmed the physician had not been made aware.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 835	Continued From page 137	F 835		

Interview with the Regional Nursing Consultant (RNC) and Regional Director of Operations (RDO) on 2/14/24 at 3:05 PM, confirmed they were not aware Resident #20 had not had a bowel movement (BM) since 2/04/24. They both revealed that a situation such as that should be taken seriously, and the physician should have already been notified and that they would take care of it right away.

Record review of the progress Notes for Resident #20 dated 2/14/24 at 15:52 (3:52 PM) revealed, "Note Text: Resident has not had a bm since 2/04/24. This nurse notified (Proper Name of Doctor) and he gave a one time order for lactulose. He also gave an order for xray flat and upright. This was ordered by the nurse."

Record review of Resident #20's Abdominal X-Ray report dated 2/14/24 revealed under, "Impression: 1. No free air or bowel obstruction. 2. Moderate stool in colon compatible with constipation." ...

Record review of the "Transfer/Discharge Report" revealed the facility admitted Resident #20 on 1/24/22 with medical diagnoses that included Alzheimer's disease, Rheumatoid Arthritis, and Wedge compression fracture of T 11-T 12 vertebra, subsequent encounter for fracture with delayed healing.

Record review of Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 01/10/24 revealed a Brief Interview for Mental Status (BIMS) score of 03 which indicated the resident had severe cognitive impairment. Prior MDS's dated 09/18/23 revealed a BIMS of 11, MDS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 835	Continued From page 138	F 835		

dated 12/11/23 revealed a BIMS of 9.

Resident #13 Cross reference F600, F692, F580, F684

Interview on 2/14/24 at 11:40 AM, the DON revealed Resident #13 had a significant weight loss which was not reported to the physician for interventions, therefore, her weight continued to decrease. She confirmed the facility neglected to recognize, evaluate, and address the resident's weights, failed to notify the physician of the weight decline, and failed to consult the RD, therefore, appropriate evaluations and interventions were not ordered or initiated which put the resident at risk for a continued weight loss. She confirmed these failures of the facility's administration led to a significant weight loss of 6.92% during Resident #13's first month at the facility and to a 17.52% weight loss during her first four months at the facility.

InterIview with the facility's Regional Nurse Consultant on 2/15/24 at 8:45 AM, revealed the physician nor the nurse practitioner were notified of Resident #13's significant weight loss and therefore, no interventions were initiated and weight continued to decline. She confirmed the facility's Administration was responsible for overseeing the residents' care and ensuring the needed services were available and received, but the facility's administration failed to do this. She confirmed the facility neglected to identify, evaluate, and intervene for nutritional concerns and, therefore, an avoidable weight loss occurred due to the facility Administration's failure to appropriately manage the resident's nutritional needs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 835	Continued From page 139	F 835		

Record review of Resident #13's Admission Record revealed she was admitted to the facility on 10/2/23. Diagnoses included Stevens-Johnson Syndrome, Non-pressure Ulcers, Anxiety Disorder, Major Depressive Disorder.

Record review of Resident #13's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 12/12/23 revealed a Brief Interview for Mental Status (BIMS) of 12 which indicated the resident had moderate cognitive impairment.

The facility submitted the following removal plan:

On 02/13/2024 at 4:30 PM the Mississippi State Department of Health (MSDH) state survey team notified the Administrator of an Immediate Jeopardy for failing to ensure processes were in place to review and implement Registered Dietician (RD) recommendations, notify the physician of weight loss, and implement interventions to address weight loss for Resident #20, who had lost 40.5 lbs in the last six months. Resident #20 also had nausea and vomiting and was not eating or drinking adequately for the last three weeks and the facility had failed to notify the physician of the significant change. The facility failed to follow care plan interventions to identify weight loss and address weight loss for Resident #20. The facility failed to have an effective Quality Assurance and Performance Improvement (QAPI) meeting to ensure all recommendations from the Registered Dietician were addressed in a prompt manner. Review of facility processes revealed that the recommendations from the registered dietician was being sent to the Dietary Manager via email and the emails were not received and not presented to the interdisciplinary

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 835	Continued From page 140	F 835		

team and reviewed by the provider and implemented. Interview with staff indicates that resident has had poor appetite since January, and it was not documented in the medical record.

On 02/11/2024 at 6:27 PM, the facility nurse notified the provider and obtained orders for anti-emetic.

On 2/12/2024 at 9:27 am, the facility attempted to transfer resident to the emergency room for evaluation and treatment as indicated. The Responsible Party refused for resident to be sent to the emergency room on this date. The facility obtained a physician's order for hospice services.

On 02/13/2024 5:00 PM, In-services began on Abuse and Neglect for all staff by the Assistant Director of Nursing. All staff will be trained prior to returning to work. In-services began by Assistant Director of Nursing on Documentation, Provider Notification, and Change of Condition. All staff will be trained prior to returning to work.

On 02/13/2024 at 5:15 PM, Social Services and Medical Records Nurse interviewed all residents regarding Nausea and Vomiting to ensure all significant changes of conditions were reported to the providers. It was noted upon interview that nine (9) residents reported recent complaints of nausea and vomiting, one (1) resident noted to have yellow discharge from mouth and nose, 1 resident was unable to recall when nausea or vomiting occurred with no staff being knowledgeable of nausea or vomiting, two (2) residents reported nausea or vomiting after eating, 2 residents reported not having appetite or eating, 1 resident reported nausea but did not report to nurse, 2 residents reported nausea and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 835	Continued From page 141 medications received. On 02/13/2024 at 5:30 PM, all residents were audited for weight loss by the Director of Nursing, Regional Nurse Consultant, and Minimum Data Set Nurse. Results of weight loss audit were reviewed by the medical director (15 unplanned weight losses, 1 planned) and new orders and diagnoses were provided by the medical director. All nutrition care plans audited by Minimum Data Set Nurse on 02/13/2024 with 5 residents whose registered dieticians' recommendations were not on care plans, dietary recommendations reviewed with providers and orders received per providers. On 02/13/2024 at 6:05 PM, the Director of Nursing notified the physician of all 9 residents, notified the Institutional Specialized Needs Plan (ISNP) nurse practitioner of all residents (4) and hospice of all residents (1) with Nausea and Vomiting with new orders received from provider. 1 resident reviewed with new orders for chest x-ray due to cough, congestion, and yellow discharge from mouth and nose, 2 residents were ordered medications for reflux, 1 resident noted to be receiving antibiotics and has orders in place for anti-emetic medications, 1 resident reported abdominal pain and MD was notified and seen resident on 02/12/2024 with new orders for stool softener, 1 resident noted to have diarrhea and has been antibiotics new orders received for Zofran and anti-diarrheal, 1 resident noted to have weight loss and nausea and vomiting new orders received on 2/11/2024 to start Zofran and start peri-actin the family was not agreeable to start peri-actin and wanted to wait to speak to hospice on 02/14/2024, 2 residents did not report nausea to nurses at time of occurrence.	F 835		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 835	Continued From page 142	F 835		

On 02/13/2024 at 6:59 PM, Social Services and Medical Records nurse interviewed residents with BIMS 10 or higher to ensure feeling of safe and are free of health concerns, no health or safety concern during interviews.

On 02/13/2024 at 8:30 PM, all Registered Dietician recommendations for last 90 days audited by Dietary Manager and Minimum Data Set Nurse with 5 residents whose registered dietician recommendations were not addressed. All Dietary recommendations reviewed with the Medical Director (5) and subsequent providers as appropriate Hospice (2 residents who have been on hospice services prior to survey entrance) and Institutional Special Needs Program nurse practitioner (1), new orders received from providers as appropriate.

On 02/13/2024 at 8:40 PM, All nutrition care plans audited by Minimum Data Set Nurse with 5 residents whose registered dieticians' recommendations were not on care plans, dietary recommendations reviewed with providers and orders received per providers and care plans updated.

On 02/13/2024 at 9:00 PM, all residents noted with weight loss were reviewed with the Medical Director, the Medical Director performed medication review on all residents with weight loss.

Ad Hoc QAPI was held on 02/13/2024 at 10:15 PM with the Medical Director via phone, Administrator, Director of Nursing, Social Services, Minimum Data Set Nurse, Life Connections Coordinator, Regional Nurse Consultant, Regional Director of Operations,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 835	Continued From page 143	F 835		

Assistant Director of Nursing, Registered Nurse Supervisor, Dietary Manager, and Medical Records Nurse. The Minimum Data Set Nurse has been designated as the Quality Assurance Nurse with responsibility reviewing all audits, Performance Improvement Plans, Quality Measures, and actively participating in the Quality Assurance and Performance Improvement meetings. All areas of deficiencies were reviewed in Ad-Hoc Quality Assurance and Performance Improvement meeting. Medical Records nurse or Assistant Director of Nursing will be responsible for receiving Registered Dietician recommendations, reviewing with providers, entering orders, and progress notes. New processes for Medical Director to review facility weight losses each week on visit, Registered Dietitian recommendations to be reviewed weekly with the Interdisciplinary Team and the Medical Director by Friday, in the event Registered Dietician recommendations are not received, the medical director will be notified. The Dietary Manager will review the weight and vital sign exception report and present findings in the clinical meeting. The Director of Nursing will review weights and registered dietician recommendations. The Director of Nursing will review progress notes daily. The administrator will review the audit findings weekly. All results will be reviewed in Quality Assurance and Performance Improvement meetings.

On 02/13/2024 at 10:00 PM, One-on-one Inservice conducted with Administrator by the Regional Director of Operations for weights, care plans, Quality Assurance and Performance Improvement, Notifying Physicians, Registered Dietician Recommendations, Documentation, and Administration Processes. The Regional Nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 835	Continued From page 144	F 835		

Consultant conducted one-on-one in-services with the Director of Nursing, Dietary Manager, Assistant Director of Nursing, Medical Records Nurse, and Minimum Data Set Nurse regarding weights, care plans, Quality Assurance and Performance Improvement, Notifying Physicians, Registered Dietician Recommendations, Documentation and Administration Processes. One-on-one in-service conducted with the Dietary Manager by the Administrator regarding Communication of Dietary Recommendations, Review of Recommendations, and reporting any identified areas of concerns with Dietary Recommendations. All nurses who provided care to resident #20 for the previous 3 weeks were provided One-on-one in-services regarding reporting changes of condition to provider, documentation, and following plan of care then were provided with a post-test to confirm understanding of one-on-one in-services.

As of 02/14/2024, the facility alleges compliance and all corrective action completed on 02/13/2024.

The Survey Agency (SA) validated the facility's Corrective Actions on 2/20/24:

The SA validated through record review that Resident #20 was ordered an anti-emetic for nausea/vomiting.

The SA validated through interview and record review that in-services were conducted for Abuse and neglect, documentation, provider notification, and change of condition. No staff can return to work until they have received in-services.

The SA validated through record review that all

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 835	Continued From page 145	F 835		

residents were interviewed and screened for symptoms of nausea and vomiting and the physician was notified of the findings with physician orders if appropriate.

The SA validated through record review and staff interview that all residents were audited for weight loss and the Medical Director was updated. All nutrition care plans were audited and updated with dietary recommendations.

The SA validated through record review that all residents with a Brief Interview for Mental Status (BIM's) of 10 or higher were interviewed to ensure feeling safe in their environment and free from health concerns.

The SA validated through record review that all Registered Dietician (RD) recommendations were audited and addressed with the provider as appropriate.

The SA validated the Medical Director reviewed the resident with weight loss and performed medication review.

The SA validated through staff interview and record review on 2/20/24 that an Emergency Quality Assurance and Performance Improvement (QAPI) meeting was conducted on 2/13/24 with all members in attendance.

The SA validated through record review and staff interview that one-on-one in-services were conducted on weights, care plans, Quality Assurance and Performance Improvement (QAPI), notifying physicians, reporting changes, Registered Dietician Recommendations, Documentation, and Administrative Processes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 835	Continued From page 146 No staff can return to work until they have received in-services. The SA validated that all corrective actions were completed on 2/13/24 and the IJ was removed as of 2/14/24.	F 835		
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(q)(1)-(5) §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(q)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed	F 851		3/19/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 851	Continued From page 147 practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(q)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(q)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility procedure review, the facility failed to submit accurate staffing data into the Payroll-Based Journal (PBJ) system for one (1) of four (4) quarters reviewed. Fourth quarter 2023. Findings include: The facility provided a document on letterhead,	F 851	1. On 02/15/2024 the Regional Director of Operations audited time entries information to determine if all entries were correct and match according to staffing schedules. 2. All time entries have the potential to be affected. 3. On 02/27/2024 the Administrator educated staff that any changes must be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 851	Continued From page 148 that revealed, "There is not a manual or a written policy on coding salary staff when they change from one position to another. There is a procedure that the Business Office Manager follows. The Business Office Manager notifies Human Resources to make the proper adjustments. The BOM also notifies Human Resources if an hourly employee worked in a different capacity other than his/her position." Signed by the Administrator on 2/14/24. Record review of "PBJ Staffing Data Report CASPER Report 1705D FY (Fiscal Year) Quarter 4 2023 (July 1-September 30)", revealed "Excessively Low Weekend Staffing-Triggered. Triggered= Submitted Weekend Staffing data is excessively low." During an interview on 02/12/24 at 10:31 AM, the Chief Clinical Officer revealed "we had an issue last quarter with coding incorrectly." During an interview on 02/12/24 at 11:05 AM, the Administrator (ADM) revealed she is also a Certified Nurse Aide (CNA), and when she or the Director of Nurses (DON) or Assistant Director of nurses (ADON) works on the weekend for adequate coverage they are supposed to let the Business Office Manager (BOM) know that they worked the weekend so their hours could be coded to reflect on the PBJ. She confirmed that they had not been notifying the BOM when they worked and that is why it triggered for low weekend staffing. During an interview on 02/14/24 at 09:55 AM, the Human Resources/Business Office Manager revealed "when a salary staff member works the weekend shift, they are supposed to let me know	F 851	reflected in the payroll system, if any salary or department works as a direct care professional, those hours must be communicated to the Business Office Manager. On 03/07/2024 the Administrator updated the time correction form to show changes to regular rotations that will include all salary personnel to be captured in the Payroll Based Journal system. On 03/07/2024 the Administrator educated department heads on the change in the process. 4. Starting on 02/27/2024, the Business Office Manager will audit all time clock entries and schedule daily times four weeks, weekly weekly four weeks, then monthly times four months to ensure that entries are accurate, the payroll system is updated, and all worked hours are reflected correctly. The Business Office Manager will report results of the audit to Quality Assurance Performance Improvement Committee (QAPI) monthly for six months starting 03/19/2024 and as needed for review and/or revision.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 851	Continued From page 149 so that I can go in and manually change the hours to reflect the correct weekend hours." She confirmed "if they don't let me know then it doesn't get changed to reflect the hours worked and that is what happened with the incorrect data being submitted."	F 851		
F 865 SS=J	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and	F 865		3/19/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 865	Continued From page 150 §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and management practices; §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF. §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides. §483.75(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that: §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and	F 865		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 865	Continued From page 151 addresses identified priorities. §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed maintain an effective Quality Assurance and Performance Improvement (QAPI) program to identify, analyze, and address residents with weight loss for two (2)	F 865	1. 1. On 02/11/2024, antiemetic medication was ordered for resident #20. Starting on 02/13/2024 the Minimum Data Set Nurse will serve as the Quality Assurance Nurse.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 865	Continued From page 152 of six (6) residents reviewed for nutrition. Resident #13 and Resident #20. The facility's Quality Assurance and Performance Improvement (QAPI) review indicated the facility's failure resulted in a lack of action to identify and address weight loss, which placed Resident #13 and Resident #20, and all other residents residing in the facility at risk for serious harm, serious injury, serious impairment, and possibly death. The State Agency (SA) identified an Immediate Jeopardy (IJ) that began on 11/02/23 when the facility failed to recognize, evaluate, and address Resident #13's nutritional needs, which resulted in an unintended significant weight loss of 6.92% (percent) in one (1) month, which further led to a significant weight loss of 17.52% (percent) in four (4) months. The facility's failure to consult a Registered Dietician (RD), notify the attending physician of a significant change in condition, and act upon the residents' weight loss, placed the resident, and all other residents residing in the facility at risk for serious negative outcomes. The IJ existed at: 42 CFR §483.75(a) Quality Assurance and Performance Improvement (QAPI) Program - F865 - Scope/Severity "J" The facility Administrator was notified of the IJ on 2/13/24 at 4:30 PM and provided the IJ Template. The facility provided an acceptable Removal Plan on 2/14/24, in which they alleged all corrective actions to remove the IJ were completed on 2/13/24 and the IJ removed on 2/14/24.	F 865	On 2/13/2024, In-service for Abuse and Neglect for all staff began by the Assistant Director of Nursing. On 02/13/2024, Social Services and Medical Records Nurse interviewed all residents for nausea and vomiting and reported to provider. On 02/13/2024, the Director of Nursing notified providers of residents with complaints of nausea and vomiting. On 02/13/2024, all residents were audited for weight loss by the Director of Nursing, Regional Nurse Consultant, and Minimum Data Set Nurse. On 02/13/2024, Providers for all residents with weight loss were notified by the Director of Nursing, Assistant Director of Nursing, and Medical Records Nurse. On 02/13/2024, a medication review for all residents with weight loss was conducted by the medical director. On 02/13/2024, Dietary Manager and Minimum Data Set Nurse audited all Registered Dietician Recommendations for the last 90 days were reviewed with provider and new orders and implemented. On 02/13/2024, all nutrition care plans were audited by the Minimum Data Set Nurse and updated to reflect dietary recommendations. Ad Hoc Quality Assurance and Performance Improvement meeting was held on 02/13/2024. On 02/13/2024,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 865	Continued From page 153 The SA validated the Removal Plan on 2/20/24 and determined the IJ was removed on 2/20/24. Therefore, the scope and severity for 42 CFR §483.75(a) Quality Assurance and Performance Improvement (QAPI) Program was lowered from a "J" to a "D" while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: Record review of the facility policy titled "Quality Assessment and Performance Improvement" undated, revealed, "Overview: The Quality Assurance and Performance Improvement (QAPI) committee will implement a process that is ongoing, multi level, and facility wide that encompasses managerial, administrative, clinical, ancillary, and environmental services as well as contracted services and suppliers. The program should address all systems of care and management practices while emphasizing safety, quality of life, and resident choice. The primary purpose of the committee is to identify and analyze actual or potential quality issues, develop and implement appropriate plans to improve performance, to address identified quality issues, and monitor the effectiveness of implemented changes. The committee will make any needed revisions to performance improvement plans. Other purpose of the QAPI committee are to maintain satisfactory, consistent functioning of systems, to prevent deviations from care processes (to the extent possible), to discern issues and concerns with facility systems, and to correct said systems as needed. The committee will ensure that information about the QAPI committee activity is provided to consultants or	F 865	Oneon-One in-services with the Director of Nursing, Dietary Manager, Assistant Director of Nursing, Medical Records Nurse, and Minimum Data Set Nurse regarding weights, care plans, notifying physician, Quality Assurance and Performance Improvement meetings, Registered Dietitian Recommendations, Documentation, and Administration were conducted by the Regional Nurse Consultant. On 02/13/2024, the Regional Director of Operations conducted and One-on-One in-service with the Administrator regarding weights, care plans, notifying physician, Quality Assurance and Performance Improvement meetings, Registered Dietitian Recommendations, Documentation, and Administration. On 02/13/2024, all nurses who provided care to resident # 20 for previous three weeks were provided one-on-one for reporting changes of condition to provider, documentation, and following plan of care and provided posttest to confirm understanding by the Director of Nursing and Assistant Director of Nursing. On 02/13/2024, Social Services and Medical Records nurse interviewed residents with a BIMS of 10 or higher to ensure residents were feeling safe in the environment and are free of health and safety concerns. On 02/14/2024, resident #20 was ordered	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 865	Continued From page 154 others who are not members of the committee but have responsibility of the Governing Body oversight. ... Governance And Leadership: The committee will consist of the facility administrator, the Director of Nursing, the Medical Director, the Infection Preventionist and at least 3 other designated key staff members. ... The facility administrator will be responsible for the effective functioning of the QAPI program but may designate one or more persons to be accountable for QAPI. ... The minutes of the monthly QAPI meeting will be reviewed with the Medical Director for input. ... The methodology utilized by the facility to identify quality concerns incorporates the following: Establishment of critical items ...Data gathering and trending including input from staff, residents, and families regarding quality problems and opportunities for improvement...Establishment of benchmarks for critical items utilizing the best available evidence to define goals ... Utilization of root cause analysis" Resident #20 Record review of Resident #20's weights revealed a significant weight loss of 13.9% (percent) in one (1) month, 21.6% (percent) in three (3) months, and 26.2% (percent) in six (6) months. The Dietary Manager (DM) interview on 2/13/24 at 8:13 AM, revealed she was new to the role and had been in the position since June 2023. She revealed the facility had weekly PAR (Patients at Risk) meetings where the weights were discussed. She stated all the department heads attend the meetings but that the Registered Dietician (RD) does not attend PAR or Quality	F 865	appetite stimulant. On 02/14/2024, Resident #20 was admitted to hospice services. On 02/14/2024, Resident #20 received an order for a laxative and was administered a laxative and abdominal x-ray. On 02/15/2024, resident #20 still had no results from laxative, provider was notified, and order received for enema with results noted. On 2/15/2024, resident #13 was ordered fortified cereal and fortified mashed potatoes. 2. All residents in the facility have the potential to be affected by the alleged negligent practices. 3. On 02/13/2024, appropriate staff were educated on nutritional status, care plans, reporting, documentation, and notifying provider by Assistant Director of Nurses. Starting on 03/07/2024 and completed on 03/08/2024, the Rehab Director in-serviced therapy staff to notify nurse of changes in resident conditions and concerns promptly. Beginning on 02/13/2024, the Medical Records nurse will review the nutritional report in the electronic health record for any residents with decreased meal intake percentage in clinical meetings. The Medical Records nurse will ensure that concerns are communicated to the provider, interventions are put in place and the plan of care is	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 865	Continued From page 155 Assurance and Performance Improvement (QAPI) meetings. The RD sends her recommendations and we are suppose to review them at the quarterly meetings. The Registered Dietician (RD) revealed during a telephone interview with on 2/13/24 at 9:56 AM, she worked remotely and tried to be onsite every 60-90 days. She revealed that her last visit to the facility was December 16, 2023. The RD explained she had access to the Electronic Medical Record (EMR) and was able to chart under the residents' Progress Notes or under the Miscellaneous tab. She revealed she did not attend the Quality Assurance and Performance Improvement (QAPI) meetings. The Director of Nursing (DON) interview on 2/13/24 at 10:38 AM, revealed she had been in the position since October 2023 and she had been to one (1) Quality Assurance (QA) meeting since she started and could not recall if weights were even discussed. The DON stated she had not conducted any tracking/trending on the facility's weight loss, and confirmed that she should have. She stated the Registered Dietician (RD) did not attend Quality Assurance and Performance Improvement (QAPI) meetings or the weekly PAR meetings. The Administrator (ADM) interview on 2/13/24 at 2:10 PM, revealed the last Quality Assurance and Performance Improvement (QAPI) meeting conducted on weight loss was February 7, 2024, and included audits conducted by the DON on weights, physician orders, and Dietary Consults. She revealed no other QAPI's had been conducted pertaining to weight loss, and she was unsure what the Director of Nursing (DON) had	F 865	updated at this time. Beginning on 02/13/2024, the dietary recommendations will be reviewed weekly by the DON and Dietary manager. The recommendations will be reviewed in clinical meetings for completion and documented in the resident's chart with the plan of care updated. 4. Starting 03/04/2024, the administrator will interview 5 alternating residents weekly to ensure that residents feel safe and are free of health and safety concerns for 8 weeks, then bi-weekly for 2 months, then monthly for 2 months. The administrator will take immediate corrective action as needed and notify appropriate authorities as needed. Starting 02/13/2024, the Director of Nursing will review progress notes 5 times per week for changes in resident condition and provider notification for 4 weeks, then weekly for 4 weeks, then bi-weekly times 2 months, then monthly times 2 months. The Director of Nursing will take immediate corrective action as needed. On 03/07/24, a new registered dietician began covering facility. Starting 02/13/2024, the Minimum Data Set Nurse will audit nutrition care plans weekly times 4 weeks, then bi- weekly times 2 months, then monthly times 3 months for appropriate interventions. The	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 865	Continued From page 156 completed in her tracking and trending and she confirmed that the Medical Director was not in attendance for the last meeting and stated she went over everything by phone. The Regional Nursing Consultant (RNC) interview on 2/14/24 at 5:40 PM, revealed the facility did not have a great QAPI (Quality Assurance Performance Improvement) system in place for identifying, tracking, and trending weight loss. The Administrator interview on 2/14/24 at 4:36 PM, , revealed she was the contact person for Quality Assurance and Performance Improvement (QAPI). She revealed we have a meeting monthly which includes the Director of nursing (DON), Assistant Director of Nursing (ADON), Dietary, Maintenance, Social Services and all personnel that were required. An interview with the Chief Clinical Officer (CCO) on 2/15/24 at 11:00 AM, revealed the facility has struggled with getting a Director of Nursing (DON). She stated they have had 4 DON's since the previous survey in 2022. She confirmed the facility did not have a great Quality Assurance and Performance Improvement (QAPI) program and revealed the corporate office was in the process of revamping the QAPI program so each facility will have a uniformed template to use. Record review of the QA (Quality Assurance) meeting minutes dated 1/9/24 for the month review of December 2023 revealed, " ... Director of Nursing -weights, auditing orders, and making rounds." No documentation was provided to indicate tracking and trending resident weight loss or to address what actions were put in place. The specific residents who had significant weight	F 865	Minimum Data Set Nurse will take immediate corrective action as needed. Starting 02/13/2024, the Medical Records Nurse and the Dietary Manager will audit the dietary recommendations to ensure receipt, provider notification, documentation, and implementation weekly times 4, then bi-weekly times 2 months, then monthly times 3 months. The Medical Records Nurse and the Dietary Manager will take immediate corrective action as needed. Starting 02/13/2024, the Administrator and Minimum Data Set Nurse will review all audits for compliance and identify any concerning trends weekly for 12 weeks, then monthly for 3 months. The Minimum Data Set Nurse and the Administrator will take immediate corrective action as needed. The Regional Nurse Consultant and Regional Director of Operations will review Quality Assurance and Performance Meeting Minutes Monthly to ensure deficiencies are addressed monthly starting on 03/19/2024 for 3 months. The Director of Nursing, Minimum Data Set Nurse, Medical Records Nurse, Dietary Manager, Assistant Director of Nursing, and Administrator will report audit findings to Quality Assurance and Performance Improvement committee meeting monthly times 6 months starting on 03/19/2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 865	Continued From page 157	F 865		

loss were not mentioned.

Record review of the QA (Quality Assurance) meeting minutes dated 2/7/24 for the month review of January 2024 revealed, " ... Director of Nursing -weights, auditing orders, and making rounds." No documentation was provided to indicate tracking and trending resident weight loss or to address what actions were put in place. The specific residents who had significant weight loss were not mentioned.

Record review of the "Transfer/Discharge Report" revealed the facility admitted Resident #20 on 1/24/22 with medical diagnoses that included Alzheimer's disease, Rheumatoid Arthritis, and Wedge compression fracture of T 11-T 12 vertebra, subsequent encounter for fracture with delayed healing.

Resident #13

Record review of "Weights and Vitals Summary" revealed Resident #13's weight on 10/3/23 was 166.1 pounds and a weight on 11/2/23 was 154.6 pounds which listed a comparison weight of an 11.5 pound decrease and a 6.9% weight loss. Resident #13's weight on 2/5/24 was 137 pounds and compared to the admission weight 4 months previously of 166.1 pounds on 10/3/23 listed a comparison weight of a 29.1 pound decrease and a 17.5% weight loss.

Record review of Resident #13's Admission Record revealed she was admitted to the facility on 10/2/23. Diagnoses included Stevens-Johnson Syndrome, Non-pressure Ulcers, Anxiety Disorder, Major Depressive Disorder.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 865	Continued From page 158	F 865		

The facility submitted the following removal plan:

On 02/13/2024 at 4:30 PM, the Mississippi State Department of Health (MSDH) state survey team notified the Administrator of an Immediate Jeopardy for failing to ensure processes were in place to review and implement Registered Dietician (RD)recommendations, notify the physician of weight loss, and implement interventions to address weight loss for Resident #20, who had lost 40.5 lbs in the last six months. Resident #20 also had nausea and vomiting and was not eating or drinking adequately for the last three weeks and the facility had failed to notify the physician of the significant change. The facility failed to follow care plan interventions to identify weight loss and address weight loss for Resident #20. The facility failed to have an effective Quality Assurance and Performance Improvement (QAPI) meeting to ensure all recommendations from the Registered Dietician were addressed in a prompt manner. Review of facility processes revealed that the recommendations from the registered dietician was being sent to the Dietary Manager via email and the emails were not received and not presented to the interdisciplinary team and reviewed by the provider and implemented. Interview with staff indicates that resident has had poor appetite since January, and it was not documented in the medical record.

On 02/11/2024 at 6:27 PM, the facility nurse notified the provider and obtained orders for anti-emetic.

On 2/12/2024 at 9:27 am, the facility attempted to transfer resident to the emergency room for evaluation and treatment as indicated. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 865	Continued From page 159	F 865		

Responsible Party refused for resident to be sent to the emergency room on this date. The facility obtained a physician's order for hospice services.

On 02/13/2024 5:00 PM, In-services began on Abuse and Neglect for all staff by the Assistant Director of Nursing. All staff will be trained prior to returning to work. In-services began by Assistant Director of Nursing on Documentation, Provider Notification, and Change of Condition. All staff will be trained prior to returning to work.

On 02/13/2024 at 5:15 PM, Social Services and Medical Records Nurse interviewed all residents regarding Nausea and Vomiting to ensure all significant changes of conditions were reported to the providers. It was noted upon interview that nine (9) residents reported recent complaints of nausea and vomiting, one (1) resident noted to have yellow discharge from mouth and nose, 1 resident was unable to recall when nausea or vomiting occurred with no staff being knowledgeable of nausea or vomiting, two (2) residents reported nausea or vomiting after eating, 2 residents reported not having appetite or eating, 1 resident reported nausea but did not report to nurse, 2 residents reported nausea and medications received.

On 02/13/2024 at 5:30 PM, all residents were audited for weight loss by the Director of Nursing, Regional Nurse Consultant, and Minimum Data Set Nurse. Results of weight loss audit were reviewed by the medical director (15 unplanned weight losses, 1 planned) and new orders and diagnoses were provided by the medical director. All nutrition care plans audited by Minimum Data Set Nurse on 02/13/2024 with 5 residents whose registered dieticians' recommendations were not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 865	Continued From page 160	F 865		

on care plans, dietary recommendations reviewed with providers and orders received per providers.

On 02/13/2024 at 6:05 PM, the Director of Nursing notified the physician of all 9 residents, notified the Institutional Specialized Needs Plan (ISNP) nurse practitioner of all residents (4) and hospice of all residents (1) with Nausea and Vomiting with new orders received from provider. 1 resident reviewed with new orders for chest x-ray due to cough, congestion, and yellow discharge from mouth and nose, 2 residents were ordered medications for reflux, 1 resident noted to be receiving antibiotics and has orders in place for anti-emetic medications, 1 resident reported abdominal pain and MD was notified and seen resident on 02/12/2024 with new orders for stool softener, 1 resident noted to have diarrhea and has been antibiotics new orders received for Zofran and anti-diarrheal, 1 resident noted to have weight loss and nausea and vomiting new orders received on 2/11/2024 to start Zofran and start peri-actin the family was not agreeable to start peri-actin and wanted to wait to speak to hospice on 02/14/2024, 2 residents did not report nausea to nurses at time of occurrence.

On 02/13/2024 at 6:59 PM, Social Services and Medical Records nurse interviewed residents with BIMS 10 or higher to ensure feeling of safe and are free of health concerns, no health or safety concern during interviews.

On 02/13/2024 at 8:30 PM, all Registered Dietician recommendations for last 90 days audited by Dietary Manager and Minimum Data Set Nurse with 5 residents whose registered dietician recommendations were not addressed. All Dietary recommendations reviewed with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 865	Continued From page 161	F 865		

Medical Director (5) and subsequent providers as appropriate Hospice (2 residents who have been on hospice services prior to survey entrance) and Institutional Special Needs Program nurse practitioner (1), new orders received from providers as appropriate.

On 02/13/2024 at 8:40 PM, All nutrition care plans audited by Minimum Data Set Nurse with 5 residents whose registered dieticians' recommendations were not on care plans, dietary recommendations reviewed with providers and orders received per providers and care plans updated.

On 02/13/2024 at 9:00 PM, all residents noted with weight loss were reviewed with the Medical Director, the Medical Director performed medication review on all residents with weight loss.

Ad Hoc QAPI was held on 02/13/2024 at 10:15 PM with the Medical Director via phone, Administrator, Director of Nursing, Social Services, Minimum Data Set Nurse, Life Connections Coordinator, Regional Nurse Consultant, Regional Director of Operations, Assistant Director of Nursing, Registered Nurse Supervisor, Dietary Manager, and Medical Records Nurse. The Minimum Data Set Nurse has been designated as the Quality Assurance Nurse with responsibility reviewing all audits, Performance Improvement Plans, Quality Measures, and actively participating in the Quality Assurance and Performance Improvement meetings. All areas of deficiencies were reviewed in Ad-Hoc Quality Assurance and Performance Improvement meeting. Medical Records nurse or Assistant Director of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 865	Continued From page 162	F 865		

will be responsible for receiving Registered Dietician recommendations, reviewing with providers, entering orders, and progress notes. New processes for Medical Director to review facility weight losses each week on visit, Registered Dietitian recommendations to be reviewed weekly with the Interdisciplinary Team and the Medical Director by Friday, in the event Registered Dietician recommendations are not received, the medical director will be notified. The Dietary Manager will review the weight and vital sign exception report and present findings in the clinical meeting. The Director of Nursing will review weights and registered dietician recommendations. The Director of Nursing will review progress notes daily. The administrator will review the audit findings weekly. All results will be reviewed in Quality Assurance and Performance Improvement meetings.

On 02/13/2024 at 10:00 PM, One-on-one Inservice conducted with Administrator by the Regional Director of Operations for weights, care plans, Quality Assurance and Performance Improvement, Notifying Physicians, Registered Dietician Recommendations, Documentation, and Administration Processes. The Regional Nurse Consultant conducted one-on-one in-services with the Director of Nursing, Dietary Manager, Assistant Director of Nursing, Medical Records Nurse, and Minimum Data Set Nurse regarding weights, care plans, Quality Assurance and Performance Improvement, Notifying Physicians, Registered Dietician Recommendations, Documentation and Administration Processes. One-on-one in-service conducted with the Dietary Manager by the Administrator regarding Communication of Dietary Recommendations, Review of Recommendations, and reporting any

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 865	Continued From page 163	F 865		

identified areas of concerns with Dietary Recommendations. All nurses who provided care to resident #20 for the previous 3 weeks were provided One-on-one in-services regarding reporting changes of condition to provider, documentation, and following plan of care then were provided with a post-test to confirm understanding of one-on-one in-services.

As of 02/14/2024, the facility alleges compliance and all corrective action completed on 02/13/2024.

The Survey Agency (SA) validated the facility's Corrective Actions on 2/20/24:

The SA validated through record review that Resident #20 was ordered an anti-emetic for nausea/vomiting.

The SA validated through interview and record review that in-services were conducted for Abuse and neglect, documentation, provider notification, and change of condition. No staff can return to work until they have received in-services.

The SA validated through record review that all residents were interviewed and screened for symptoms of nausea and vomiting and the physician was notified of the findings with physician orders if appropriate.

The SA validated through record review and staff interview that all residents were audited for weight loss and the Medical Director was updated. All nutrition care plans were audited and updated with dietary recommendations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 865	Continued From page 164 The SA validated through record review that all residents with a Brief Interview for Mental Status (BIM's) of 10 or higher were interviewed to ensure feeling safe in their environment and free from health concerns. The SA validated through record review that all Registered Dietician (RD) recommendations were audited and addressed with the provider as appropriate. The SA validated the Medical Director reviewed the resident with weight loss and performed medication review. The SA validated through staff interview and record review on 2/20/24 that an Emergency Quality Assurance and Performance Improvement (QAPI) meeting was conducted on 2/13/24 with all members in attendance. The SA validated through record review and staff interview that one-on-one in-services were conducted on weights, care plans, Quality Assurance and Performance Improvement (QAPI), notifying physicians, reporting changes, Registered Dietician Recommendations, Documentation, and Administrative Processes. No staff can return to work until they have received in-services. The SA validated that all corrective actions were completed on 2/13/24 and the IJ was removed as of 2/14/24.	F 865		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880		3/19/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 880	Continued From page 165	F 880		

The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 880	Continued From page 166 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review, the facility failed to ensure hand hygiene was performed during medication pass to prevent the spread of infection for four (4) of eleven residents observed during medication pass. Resident #20, Resident #48, Resident #55, and Resident #211 Findings Include: Record review of the facility policy titled "Handwashing" dated June 1, 2000, revealed "Policy Statement: It is the policy of this facility	F 880	1. Nurse #3 was removed from the medication cart and sent home on 2/14/24. Residents were assessed by Director of Nursing on 02/14/2024. Medical Director was notified on 02/14/2024 with no new orders. 2. The alleged deficient practice has the potential to affect all residents. 3. Nurse #3 completed documentation in--service, hand hygiene check-offs, and medication administration in-service and check-offs	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 880	Continued From page 167 that handwashing be regarded as the single most important means of preventing the spread of infection. Procedure: 1. All personnel shall wash their hands to prevent the spread of infection and disease to other residents, personnel, and visitors .... 7. Alcohol gel may be used during med pass for three times before washing hands." During an observation of medication pass on 2/14/24 at 7:55 AM, Licensed Practical Nurse (LPN) #3 prepared medications for Resident #211, entered the resident's room and applied gloves, administered the medications, removed the gloves, and exited the resident's room without performing hand hygiene. She then prepared and administered medications for Resident #48 and Resident #55 without performing hand hygiene. Lastly, she prepared Resident #20's medication, entered the resident's room, applied gloves, administered eye drops in both eyes, and exited the room without using hand hygiene. She returned to the medication cart and began to prepare medications for another resident. An interview with LPN #3 on 2/14/24 at 8:30 AM, confirmed that she administered medications to four (4) residents and did not perform hand hygiene. She revealed that the purpose of hand hygiene was to kill germs and prevent the spread of infection. She stated that she should have used hand sanitizer before and after each resident. An interview with the Regional Nurse Consultant (RNC) on 2/15/24 at 8:15 AM, revealed the purpose of hand hygiene was to reduce the risk of cross contamination and the spread of infection. She stated hand hygiene should be done before and after contact with a resident.	F 880	on 02/15/2024 prior to returning to work. Nurse #3 was checked off by Assistant Director of Nursing. Starting on 02/14/2024, licensed staff were educated by Assistant Director of Nursing on hand hygiene with a post test to confirm understanding, and completed skills check off for hand hygiene with alcohol based rub and handwashing. 4. The Assistant Director of Nursing will observe medication administration weekly 4 weeks, biweekly times 4 weeks, then monthly times 2 months to ensure hand hygiene is conducted appropriately during medication administration starting 03/04/2024. The Assistant Director of Nursing will take immediate corrective action as needed. Licensed staff will complete hand hygiene check offs upon hire and annually beginning 2/14/2024. The Assistant Director of Nursing will report audit findings to Quality Assurance and Performance Improvement Committee monthly, starting on 03/19/2024 for 3 months and as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 880	Continued From page 168 Record review of a document titled "Med pass points", undated and unsigned, revealed, "...Infection control: Wash hands or use hand sanitizer in between each resident. Actually look at it more specifically as exiting and re-entering a room even if you are still working on the same person ..." Record review of the "Handwashing Training" dated 1/24/24 revealed under, "Hand hygiene with alcohol based hand rubs: In most situations, the preferred method of hand hygiene is with an alcohol based hand rub .... a. Before and after direct contact with residents ... d. Before preparing or handling medications ... j. After removing gloves" ... Licensed Practical Nurse (LPN) #3 was in attendance for the in-service.	F 880		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and facility policy review, the facility failed to ensure a resident had access to the call light system for (1) of 60 residents on initial tour. Resident #8.	F 919	1. Resident #8 and roommate were moved to another room on 02/12/2024 where both residents have their own separate call light. 2. The alleged deficient practice has the	3/19/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 919	Continued From page 169 Findings include: Record review of facility policy titled, "Call System, Resident", undated, revealed, " ...Residents are provided with a means to call staff directly for assistance through a communication system that directly calls a staff member or a centralized work station. Policy Interpretation and Implementation: 1. Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor..." An interview with the Director of Nursing (DON) on 2/11/24 at 4:30 PM, revealed Resident #8 was living in this room and when her son was discharged from the hospital and returned to the facility on 02/10/24, Resident #8 wanted her son to be in the room with her so she could take care of him. She stated this room was small and designed for one person, but the resident wanted to be with her son, so "we put them together in here to see how it works out". She stated one call light is shared since beds are close. On 2/11/24 at 5:10 PM, an observation of Resident #8's room and an interview with Resident #8 revealed her son had been in the hospital and when he was discharged from hospital and returned to facility, he moved into the room with her so she could take care of him. She stated her son had been sick and she wanted to be there to care for him since "he's not doing well". She stated her son had a call light but she did not have one and "they need to get me one, too". The observation revealed one call light/cord attached to the one call light outlet available in the room.	F 919	potential to affect all residents. 3. Resident #8□s previous room will be converted to a single resident room beginning 02/12/2024 due to only one call light outlet present in room. 100% call light audit completed on 02/12/2024 by Administrator to ensure all residents had access to their own call light and all call lights were working properly. 4. 03/04/2024 Maintenance Director will monitor all call lights to ensure they are working properly weekly times 4 weeks, then biweekly times 2 weeks, then monthly times 2 months. Maintenance Director will report audit findings to Quality Assurance and Performance Improvement Committee monthly starting on 03/19/2024 for 3 months and as needed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

(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 919	Continued From page 170	F 919		

During an interview on 2/12/24 at 4:00 PM, the Maintenance Director stated the room Resident #8 and her son were in was designed for one resident and had only one call light and one call light outlet. He stated in the past, he had an adapter cord that split one call light outlet into two call light cords, but this divider was not being used and the room only had one call light cord available. He confirmed there were two residents in the room and there was only one call light available for use by one resident and each resident should have access to a call light.

An interview with the Director of Nursing (DON) on 2/12/24 at 4:20 PM, revealed Resident #8's room was designed for one resident, not two, and only one call light was available for use for one resident. The DON confirmed a call light must be available and within reach for each resident to use to contact staff when assistance was needed to ensure each resident could receive prompt care. The DON confirmed the facility failed to provide Resident #8 with a call light and therefore, she was unable to contact staff if assistance was needed.

Record review of Resident #8's Admission Record revealed the resident was admitted to the facility on 10/18/23. Her diagnoses included, Dementia, Polyneuropathy, Major Depressive Disorder, Anxiety Disorder, Dizziness.

Record review of Resident #8's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 2/6/24, revealed the resident had a Brief Interview for Mental Status (BIMS) of 8, which indicated the resident was moderately cognitively impaired.