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 _____	C 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	F 000		

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"

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

Electronically Signed | 03/14/2024

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F 000	Continued From page 1 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	F 000		

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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 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff and resident interview, record review, and facility policy review, the facility failed to investigate and report an allegation of abuse for one (1) of 18 residents sampled. Resident #8 Findings include: Record review of facility policy titled "Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating", dated 10/22,	F 610	1. On 2/14/2024, the Administrator reported allegation of abuse to state agency, the local ombudsman, the resident representative, law enforcement, and her attending physician/medical director the allegation of Resident #8 and began her investigation. On 02/18/2024, the final report was sent to state agency unsubstantiating the allegation.	3/19/24

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F 610	Continued From page 3 revealed, "Policy Statement: All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. Policy Interpretation and Implementation ...1. If resident abuse...is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. 2. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing /certification agency responsible for surveying /licensing the facility; b. The local/state ombudsman; c. The resident's representative; d. Adult protective services (where state law provides jurisdiction in long-term care); e. Law enforcement officials; f. The resident's attending physician; and g. The facility medical director. 3. 'Immediately' is defined as: a. within two hours of an allegation involving abuse or result in serious bodily injury; or b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury ...Investigating Allegations: 1. All allegations are thoroughly investigated. The administer initiates investigations ..." An observation and interview on 2/14/24 at 10:05 AM, revealed Resident #8 was sitting in her wheelchair in her room and rubbing her left shoulder. She stated her left shoulder was bothering her today and it had been bothering her since the nurse threw her against the wall. She revealed she gave her son some water and the nurse was angry, grabbed her arm, and	F 610	2. The alleged deficient practice has the potential to affect all residents. 3. On 02/13/2024, the Regional Director of Operations (RDO) in-serviced the Administrator on the facility policy for reporting and investigating abuse, neglect, exploitation or theft/misappropriation as well as injuries of unknown origin. On 02/13/2024, the RDO in-serviced the Administrator on immediately reporting their suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility; b. The local/state ombudsman; c. The Residents representative; d. Adult protective services (where state law provides jurisdiction in long-term care); e. Law enforcement officials; f. The residents attending physician; and g. The facility medical director. Immediately is defined as: a. within two hours of an allegation involving abuse or resulting in serious bodily injury; or b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. Administrator in-serviced staff starting 02/26/2024 and completed by 03/18/2024 with a posttest to confirm understanding on the facility policy for immediately reporting and investigating abuse, neglect, exploitation or theft/misappropriation and injuries of unknown origin. Staff will be in-serviced on abuse and neglect policy upon hire and as needed beginning 02/13/2024. 4. Starting 03/04/2024, the Administrator	

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F 610	Continued From page 4 intentionally pushed her into the wall which hurt her shoulder and she reported this to the staff. During an interview on 2/14/24 at 10:10 AM, Licensed Practical Nurse (LPN) #1 revealed there was an incident when a Certified Nursing Assistant (CNA) informed her she had witnessed Resident #8 pouring out her son's thickened water and replacing it with regular water. She stated she went to the room and explained to Resident #8 that regular water could make her son sick, but the resident got angry and told her that she could give her son water if she wanted to. She stated the resident was in her wheelchair, but tried to get out of her wheelchair so she assisted her through the doorway into the hallway and the resident started to propel herself to her room. She stated the resident then complained of pain in her left shoulder and told LPN #1 that she bumped it on the door when she was in the bathroom. LPN #1 stated that Resident #8 then told her, "The nurse threw her on the floor" and "The nurse grabbed her by the hair and drug her out of the room". The resident returned to her room and told her roommate's visitor that she had been abused and that she was thrown on the floor by the staff and the roommate's visitor reported this to her. LPN #1 stated she reported this allegation of abuse to the Director of Nursing (DON) and wrote a statement on the events that occurred. A body audit was done and no bruising or redness of her skin was found and her only complaint was that her shoulder was sore. She stated the resident had a fracture in that shoulder prior to being in the facility and had pain in that shoulder prior to this allegation. She stated she had been in-serviced on abuse and neglect and reporting and she denied that she threw the resident against the wall or hurt the resident in	F 610	will conduct walking rounds and interview five alternating residents to ensure residents feel safe and are free of concerns with safety and concerns times 4 weeks, bi-weekly times 4 weeks, monthly x times and as needed thereafter. If concerns are noted, the Administrator will take the appropriate actions. Administrator 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.	

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F 610	Continued From page 5	F 610		

any other way.

An interview with the DON on 2/14/24 at 10:15 AM, revealed she was aware of the allegation of abuse from Resident #8 and confirmed she spoke with the staff and received their statements. She spoke with the resident who told her a different scenario of what happened including she was thrown on the floor and she was walking and the nurse pushed against the wall. She stated since the resident was unable to walk and with the resident's different recollections of event, she felt that the allegation was not substantiated so therefore she didn't report it. She revealed she had been in-serviced on abuse and neglect and reporting and did not remember discussing this allegation with the Administrator, who was the person responsible for reporting, so she was unsure if this was reported to the required entities. The DON confirmed she failed to notify the Administrator of the allegation of abuse and did not follow up with reporting.

During an interview on 2/14/24 at 10:20 AM, the Administrator stated she was aware that Resident #8 received a shoulder x-ray due to pain from an injury she had prior to her admission to the facility, but she was unaware of any abuse allegation concerning this resident. She stated there was poor communication between the staff and she was not informed of the allegation.

An interview with the Administrator on 2/14/24 at 10:45 AM, confirmed the DON and other staff members were aware of the allegation of abuse concerning Resident #8, but she was not notified, therefore, the facility failed to investigate and report the allegation of abuse as required.

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F 610	Continued From page 6 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, and Intervertebral Disc Disorder. Record review of Resident #8's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/6/24, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 8, which indicated the resident had a moderate cognitive impairment.	F 610		
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- §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	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	3/19/24

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F 759	Continued From page 7 "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) (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..."	F 759	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 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	

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F 759	Continued From page 8 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. 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.	F 759	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.	

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F 759	Continued From page 9 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. 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	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	3/19/24

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F 760	Continued From page 10 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 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	F 760	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 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	

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 _____	C 02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 760	Continued From page 11 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	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 as needed.	