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 08/01/2024

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 Complaint Investigations at the facility July 31, 2024 through August 1, 2024. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid Services and cited F689 for failure to ensure the supervision and safety of a resident was maintained during facility transport related to CI MS # 25671. CI MS# 26013 was investigated related to an allegation of abuse and no deficiencies were cited. The census at the time of the survey was 65 with a bed capacity of 66 beds.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record reviews, and facility policy review, the facility failed to ensure a resident was kept free from an accident resulting in an injury during facility transport for one (1) of (4) residents reviewed for accidents. Resident #1. Findings include: A record review of the facility's policy titled, "Accidents and Incidents" undated revealed,	F 689	1. On 6/20/2024, the resident was immediately moved onto sidewalk and away from the van where she was assessed by Nurse Practitioner and Licensed Practical Nurse. Pressure dressing was applied to resident's leg laceration and emergency services were notified and transported resident to the hospital. Transportation Certified Nursing Assistant and other Certified Nursing	8/22/24

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

Electronically Signed | 08/13/2024

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F 689	Continued From page 1 Policy: It is the policy of this facility that the resident environment remains as free of accidents and hazards as possible and those residents receive supervision and assistance devices to prevent accidents whenever possible. This is accomplished through the identification and evaluation of environmental hazards and individual risk factors, implementing interventions to reduce hazards and risks that are identified, and monitoring for the effectiveness of the interventions..." A record review of Emergency Department Note date of service: 06/20/24 revealed, Resident #1 with a chief complaint of Extremity Laceration. (EMS states that facility told them that patient was in wheelchair that wasn't locked, and the wheelchair rolled into the bumper of a car. Patient's left leg was caught between the wheelchair and the car's bumper and cut her leg.)... Musculoskeletal: Comments: Left leg with a large 8-inch laceration muscle exposed anterior tib-fib (tibia/fibual) In an interview on 7/31/24 at 12:40 PM, Certified Nurse Aide (CNA) #1 revealed she is the transport CNA for the facility, which involves loading the residents onto the facility van and driving them to their appointments. She revealed the day that Resident #1 got hurt, she had an assistant helping her and the assistant had asked where the van keys were. She revealed she locked the resident's wheelchair, left the resident, and was going around the back of the van to give her assistant the keys. She revealed when she got behind the van she heard Resident #1 yell, "Help." She revealed she went back around to the resident, and the resident wasn't up against the van, but she had blood in her shoe. She	F 689	Assistant were suspended immediately pending investigation on 6/20/2024 by Administrator. 2. All residents have the potential to be affected. 3. The Transportation Certified Nursing Assistant was provided education and return demonstration by Maintenance Director on Facility Vehicle Policy and Procedures and How to Properly Secure a Wheelchair for Transportation before returning to work on 6/24/2024. Staff, including Transportation Certified Nursing Assistant, were inserviced by Director of Nursing on Abuse and Neglect, Resident Safety, Incidents and Accidents, Resident Rights, Not leaving residents unattended in an unsafe environment, and locking wheelchairs beginning 6/20/2024. 4. The Maintenance Director will observe Transportation Certified Nursing Assistant beginning 6/24/2024 during boarding and transportation of residents onto the van daily x 1 week, then twice a week x 2 weeks, then weekly x 1 month. The Maintenance Director will report any findings to the Quality Assurance and Performance Improvement Committee on 7/23/2024 and 8/20/2024 x 2 months.	

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F 689	Continued From page 2	F 689		

confirmed she did lock the wheelchair, however, she did leave the resident alone to go and give the other CNA the keys.

During a phone interview on 7/31/24 at 12:45 PM, the Psychiatric Nurse Practitioner revealed she was pulling into the facility parking lot on 6/20/24 and saw the resident roll down in her wheelchair unassisted and hit her left leg on the end of the van. She revealed when she got up to the van the resident was bleeding and went inside and reported the incident.

During an interview on 7/31/24 at 2:40 PM, a Licensed Practical Nurse (LPN) revealed on that 6/20/24, Resident #1 had a doctor's appointment and was being transported by the facility van. She revealed the Psychiatric Nurse Practitioner came inside and informed me that a resident was outside and was bleeding and needed help. She revealed "When I got outside to assess the situation, it was bad. The resident had a severe laceration to her left leg. It took us a while to get the bleeding stopped. The resident was transported by ambulance to the hospital. I don't think she (Resident #1) unlocked her wheelchair. I've never pushed her somewhere and locked her chair, and then she unlocked it. I think the wheelchair wheels were not locked and she rolled into the van."

During an interview on 7/31/24 at 3:00 PM, the Director of Nurses (DON) revealed "I don't feel like the wheelchair wheels were locked, and if they were locked, I don't think she (Resident #1) would have had the strength to unlock them." The DON confirmed the facility failed to ensure the safety of the resident by ensuring the wheelchair was locked, and the resident was not left

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F 689	Continued From page 3 unattended. A review of the Admission Record revealed Resident #1 was admitted to the facility on 2/08/2024 with diagnoses that included Chronic Systolic (Congestive) heart failure, Paroxysmal atrial fibrillation, Type 2 Diabetes Mellitus, and Chronic kidney disease, Stage 3A. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/13/2024 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 04, indicating severe cognitive impairment.	F 689		