STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255145	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD REHABILITATION AND HEALTHCARE	501 SOUTH LOCUST STREET MCCOMB, MS 39648

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F 000	INITIAL COMMENTS The State Agency (SA) conducted Complaint Investigations (CI MS #22621, CI MS #22694 and CI MS #22929) at the facility from 10/18/23 through 10/20/23. CI MS #22621 was investigated related to Quality of Care, Dietary Services, Resident Rights, Resident Abuse, and Physical Environment, with no deficiencies cited. CI MS #22694 was investigated for Quality of Care and Resident Rights with no deficiencies cited. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid and cited F550 related to CI MS #22929 for Resident Rights/Abuse with deficiencies cited related to Resident Rights. At the time of the survey the facility held a license for 145 beds, with a census of 104 residents.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal	F 550		11/28/23

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

Electronically Signed | 11/09/2023

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F 550	Continued From page 1 access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, interviews, and facility policy review, the facility failed to ensure residents were treated with respect and dignity for two (2) of five (5) residents reviewed. Residents #2 and #5. Findings include: Record review of the facility policy titled, "Policies and Procedures," with "Subject: Resident Rights," dated 11/30/14, revealed, "It is the policy of The Company to ...1. Ensure that residents' rights are known to staff ...5. Ongoing training on resident rights will be given to staff members as required	F 550	Upon notification of the incidents related to Resident #2 involving Certified Nurse Assistant (CNA) (#3) violating the Residents Rights, an assessment was conducted by the Director of Nurses on 9/26/23 with no injuries noted. Upon notification of the incident related to Resident #5 involving Licensed Practical Nurse (LPN) (#1) violating the Residents Rights, an assessment was conducted by the Nurse in charge with no injuries noted. CNA (#3) and LPN (#1) were suspended pending an investigation of the incidents, which resulted in termination of their	

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F 550	Continued From page 2 by state and/or federal regulations ..." Resident #2 Record review of the Facility Investigation dated 9/25/23, and an Incident Report for Resident #2, dated 9/24/23, revealed that Resident #2 had reported to the Director of Nurses (DON) that Certified Nurse Aide (CNA) #3 was "very mean and rude." Record review revealed an attached statement from Resident #2, recorded and signed by the Administrator, dated 9/26/23. In the statement, Resident #2 stated that a few days ago, which was determined to be Sunday, 9/24/23, a CNA was rude and mean to her while providing incontinent care and when asked not to be so rough, the resident stated the CNA did not respond verbally to the request, however, the resident revealed the CNA seemed to get rougher. On 10/18/23 at 10:45 AM, an interview with the Administrator revealed she was made aware of the allegation of mistreatment of Resident #2 by the Director of Nurses (DON) on 9/24/23, and a thorough investigation resulted in the end of the employment of CNA #3. The Administrator described Resident #2 as alert, oriented and well spoken. The Administrator stated that a review of the personnel folder for CNA #3 revealed previous concerns regarding treating residents rudely. On 10/19/23 at 4:20 PM, during a telephone interview with the Resident Representative (RR) for Resident #2, she revealed that the resident had been discharged from the facility due to change a in condition and was unavailable for interview because she was in the Intensive Care	F 550	employment with the facility. Interviews were conducted with residents in the same care group of Resident #2 on 9/26/2023 and with Resident #5 on 10/20/2023. No occurrences of violation of Resident Rights were revealed. Residents on census have the potential to be affected. Staff Education was initiated by the Director of Nursing related to Abuse, Neglect and Reporting Procedures with an emphasis on Residents Rights beginning 9/26/2023 and on 10/20/2023 with all staff to be completed by 11/15/2023. Staff will receive education on Resident Rights upon hire, quarterly and as needed. Social Services will conducted education each month with Residents during Resident Council meeting pertaining to their Resident Rights beginning 11-8-2023. The Quality Assurance Committee recommended Quality Review interviews be conducted and documented by Social Services or Charge Nurse beginning 11-3-2023 with (5) Residents daily for (2) weeks, then (5) Residents (3) times weekly for (2) weeks, then (5) Residents (1) times weekly for (2) weeks, then (5) Residents (1) times bi-weekly for (1) month, then monthly for (2) months. Findings revealed in the Quality Review	

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F 550	Continued From page 3 Unit (ICU) in a hospital in another state. The RR stated that she was the resident's daughter and that her mother had reported to her that CNA #3 was rude and mean to her during care on or around 9/24/23. The RR stated she was sure the resident was making an accurate allegation because "she (CNA #3) was rude to me too." On 10/19/23 at 6:20 PM, an interview with the DON confirmed that Resident #2 had reported an allegation of disrespectful treatment which resulted in suspension of CNA #3 during a thorough investigation. The DON confirmed that the employment of CNA #3 was terminated as a direct result of the investigation. She stated that the facility conducted an Education In-Service for all facility staff on 9/26/23 titled "Abuse, Neglect and Reporting, Incontinence Care Attitudes" with included instructions and policy and regulation review. The DON stated that all residents should be treated with dignity and respect, and it was against facility policy and current standards of care to treat residents otherwise. On 10/20/23 at 4:55 PM, an interview with the Administrator revealed that she stated that the facility had provided in-service training for all staff on 9/26/23 regarding Resident Rights and treating residents with respect and dignity, following an incident with Resident #2. Record review of the "Admission Record" revealed Resident #2 was admitted to the facility on 9/19/23 with diagnoses that included Hemiplegia and Hemiparesis, Acute Myocardial Infarction and Congestive Heart Failure. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of	F 550	monitoring interviews will be reported to the Quality Assurance Committee for recommendations on 11/27/2023 for 4 months.	

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9/26/23 revealed a Brief Interview for Mental Status Score (BIMS) of 15 indicating Resident #2 was cognitively intact.

Resident #5

On 10/18/23 at 12:30 PM, during an interview with Resident #5, the resident reported that last night, the resident was not sure of the time, he had slid out of his bed and that when his CNA (he did not know the CNA's name) had entered his room, she had yelled at him to "get up". He reported that when the CNA realized that he was unable to get up without assistance, she summoned the nurse and they had assisted him back into bed and left him lying in bed, "like a sack of potatoes." Resident #5 said he had to scoot himself around to get positioned in his bed. Resident #5 revealed that being yelled at and left that way in bed, left him feeling undignified. Resident #5 described his treatment by the CNA as "mean and hateful".

On 10/18/23 at 12:45 PM, in an interview with the Resident #5's roommate, an unsampled resident, he revealed that last night he woke up and saw Resident #5 on the floor. The resident stated he was unsure of the time, but realized it was still dark outside. Resident #5's roommate said the CNA who came into the room (he did not know her name) was rude and hollered at Resident #5 to "get up." Resident #5's roommate stated that he told the CNA "He can't get up, you got to help him." Resident #5's roommate commented that after they got Resident #5 back in bed, they just left him and confirmed that he saw Resident #5 moving himself around in the bed, trying to get straight.

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On 10/19/23 at 5:00 PM, an interview with the Administrator revealed she was not aware that Resident #5 had been found on the floor or that there was an allegation of disrespect or undignified treatment. She stated that the incident should have been reported to her. She stated all incidents involving falls are reviewed by the interdisciplinary team.

On 10/19/23 at 6:05 PM, an interview with Registered Nurse (RN) #1 revealed she was the RN Supervisor for the building and usually worked 8:00 AM to 4:30 PM every Monday through Friday. She stated that all incidents, including falls, were supposed to be documented by nurses and are reviewed every morning by the interdisciplinary team during their morning meeting. She stated that there had been no reported fall or allegation of mistreatment regarding Resident #5 recorded by the nursing staff on the night of 10/17/23 or predawn hours of 10/18/23. RN #1 stated that when a resident is found on the floor, it is considered a fall, and an incident report should have been done. RN #1 stated that the roommate of Resident #5 had reported an incident of a fall involving Resident #5 and disrespectful treatment by staff during Resident #5's care, on 10/19/23 at approximately 6:00 PM.

On 10/19/23 at 6:17 PM, a telephone interview with Licensed Practical Nurse (LPN) #1 revealed that Resident #5 had been located on the floor of his room next to his bed during the predawn hours of 10/18/23. LPN #1 stated that she had been summoned to Resident #5's room by CNA #4 and observed Resident #5 sitting on the floor next to his bed. She stated that she and the CNA

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#4 assisted the resident to transfer back into his bed. She stated that she could not remember if she documented any progress notes, filled out an incident report, or completed any documentation of the fall. She stated she did not notify the primary physician or the resident's RR, as the resident had stated that he slid out of bed and denied any injuries. She stated she had reported the fall to the oncoming shift during the shift change report.

On 10/19/23 at 6:20 PM, She stated she was not aware that Resident #5 had voiced an allegation of being treated with lack of respect or that he had had a fall during the nighttime hours of 10/17/23 or predawn hours of 10/18/23. She said that Resident #5 had a condition which she observed as progressing recently, leaving him weaker and less able to assist with transfers. She stated that she thought it would have been disrespectful for staff to ask to instruct the resident to do things he was not physically able to do or to leave the resident without repositioning in bed, following a floor to bed transfer.

On 10/19/23 at 6:30 PM, during a telephone interview with CNA #4, the CNA confirmed she had observed Resident #5 sitting on the floor next to his bed in his room during the predawn hours of 10/18/23 and summoned LPN #1 to the resident's room for assistance. CNA #4 stated that she kept telling him to use his legs, but he wouldn't, so she scooped his legs up onto the bed. CAN#4 commented that everything they asked him to do he, he wouldn't. CNA #4 confirmed that Resident #5 stated that he couldn't help. She confirmed that Resident #5 was not repositioned after he was assisted back into his bed. CNA #4 stated, "I didn't know what was

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wrong with him, it was never explained to me." CNA #4 did state that care instructions for each resident was available to all CNAs "on the kiosk (computer with software for documenting care)."

On 10/20/23 at 4:55 PM, an interview with the Administrator confirmed that at least three staff members had been aware of the incident which occurred in the predawn hours of 10/18/23, during which Resident #5 was observed on the floor of his room. She confirmed that "yelling" or "hollering" at a vulnerable resident on the floor to "get up" or "use his legs" and that leaving the resident without repositioning him in bed did not provide the resident with respectful or dignified care. She stated, "We are going to just keep working on it."

Record review of the "Admission Record" revealed Resident #5 was admitted to the facility on 7/7/22 with diagnoses that included Unsteadiness on feet, Other lack of coordination and Generalized anxiety disorder.

Record review of the MDS with an ARD of 8/24/23 revealed a BIMS score of 14 indicating Resident #5 was cognitively intact.