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 04/17/2024

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

(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 three (3) Complaint Investigations (CI MS #24139, CI MS #24246 and CI MS # 24470), at the facility from 4/15/24 to 4/17/24. CI MS #24139 was investigated related to improper behavior of administrative personnel. CI MS #24246 was investigated regarding quality of care, physical environment, and resident abuse and neglect. CI MS # 24470 was investigated regarding neglect of pressure wounds. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F656, F677 related to CI MS # 24246. F686 was cited related to CI MS #24470. The facility held a license for 145 beds, with a census of 121.	F 000		
F 656 SS=E	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	F 656		5/22/24

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

Electronically Signed | 05/10/2024

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 04/17/2024

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

(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 1 (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 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 interviews, record reviews and facility policy reviews, the facility failed to ensure the comprehensive care plan was implemented, as evidenced by failure to provide oral care during Activities of Daily Living (ADLs) for two (2) of six (6) sampled residents. Resident #3 and Resident #6	F 656	1) Root Cause Analysis was conducted on 4/18/2024 and based on findings Resident #3 and Resident #6 were provided oral care and provided with toothbrushes and toothpaste on 4/15/2024 by the CNA Supervisor. 2) Current Residents have the potential to	

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 04/17/2024

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

(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 2 Findings Include: Review of the facility's policy and procedure titled, "Plans of Care," revised 9/25/17, revealed, " ...Procedure...The Individualized Person-Centered plan of care may include but is not limited to the following ...Services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required by state and federal regulatory requirements ... Individualized interventions that honor the resident's preferences and promote achievement of the resident's goals ..." Resident #3 Record review of the Care Plan for Resident #3 revealed "(Proper name of Resident has an ADL self-care performance deficit r/t (related to) Activity Intolerance, Disease Process, Impaired balance ...Interventions/Task ...Personal Hygiene/Oral Care: totally dependent on staff for personal hygiene and oral care ..." During an interview on 4/15/24 with Resident #3 at 12:43 PM, he revealed that the staff assist him with some of his grooming, however, they have never assisted him in cleaning his teeth. On 4/17/24 at 9:05 AM, an interview revealed Resident #3 reiterated that he would like to brush his teeth daily. He stated "staff never offers to help me." He adds that just last week, staff told him they would bring him a toothbrush and toothpaste but as of today it has not happened yet. Record review of the "Admission Record" revealed Resident #3 was admitted to the facility	F 656	be affected 3) Education was initiated with licensed nurses and certified nursing assistants on oral hygiene by the Registered Nurse on 4/19/2024 with emphasis on providing oral hygiene care according to the Comprehensive Care Plan and providing toothbrushes and toothpaste to Residents. Education with licensed nurses conducted on Comprehensive Care Plans and implementing care plans. Education will be completed by 5/10/24. Oral care will be provided as part of the Activities of Daily Living (ADL) personal hygiene. Residents will have Comprehensive Care Plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs to include personal hygiene. New hires will be educated during orientation. 4) Quality Monitoring will be conducted starting 4/19/2024 by the Director of Clinical Services or Registered Nurse on Comprehensive Care plans to ensure care plans are followed with emphasis on oral hygiene. Monitoring will be conducted twice weekly x 4 weeks then weekly for 2 months to ensure residents have toothbrushes, toothpaste and oral care provided. Findings will be reported to QAPI Committee starting 5/20/2024 then	

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 04/17/2024

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

(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 3 on 10/16/23. Current diagnoses include Morbid (Severe) Obesity and Muscle Weakness. Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/22/24 revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated Resident #3 was cognitively intact. Resident #6 Record review of the Care Plan for Resident #6 revealed "(Proper Name of Resident #6) has an ADL self-care performance deficit r/t dx (diagnosis) of Cerebrovascular Disease with Hemiplegia/Hemiparesis on right side ...Interventions/Task ...Oral care: Requires setup or clean-up assistance ...Oral care routine ..." During an interview on 4/15/24 at 2:11 PM, Resident #6 revealed he had not received oral care since arriving at the facility in September 2023. He stated staff members promised him a toothbrush and toothpaste last week, but it has yet to arrive. Record review of the "Admission Record" revealed Resident #6 was admitted to the facility on 9/28/23. Current diagnoses include Lack of Coordination, Stiffness of Joints, and Hemiplegia and Hemiparesis Affecting Right Non-Dominant Side. Record review of the MDS with an ARD of 4/3/24 revealed Resident #6 had a BIMS score of 15 indicating no cognitive impairment. On 4/17/24 at 10:47 AM, in an interview with the Minimum Data Set (MDS), she stated that the	F 656	monthly for 3 months.	

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 04/17/2024

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

(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 4 aim of the care plan is to create a plan of care for the residents that is tailored to their specific needs. She suggests that everyone should adhere to the care plan, as it serves as a guide for how the residents' needs should be met. She stated "if it is not followed, the residents' needs will not be met." During a post survey telephone interview on 4/18/24 at 10:33 AM, with the Administrator, she revealed she expects staff to follow the residents' care plans, as they serve as an individualized guide to the care of the residents.	F 656		
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; This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record reviews, the facility failed to ensure dependent residents received Activites of Daily Living (ADL) care to include oral hygiene for two (2) or six (6) sampled residents. Residents #3 and #6 Findings Include: Record review of the facility's policy and procedure titled, "Activities of Daily Living," dated 2/1/22, revealed, "Policy: To encourage resident choice and participation in activities of daily living (ADL) and provide oversight, cuing and assistance as necessary. ADLs include bathing, dressing, grooming, hygiene, toileting and eating. Procedure: 1. CNA (Certified Nurse Aide) will	F 677	1) Root Cause Analysis was conducted on 4/19/2024 and based on findings Resident #3 and Resident #6 were provided oral care and provided with toothbrushes and toothpaste on 4/15/2024 by the Certified Nurse Assistant Supervisor. 2) Current Residents have the potential to be affected. 3) Education was initiated with licensed nurses and certified nursing assistants on oral hygiene 4/19/2024 by Registered Nurse with emphasis on providing oral hygiene care according to Comprehensive	5/22/24

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 04/17/2024

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

(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 5 review the resident Kardex (facility software that includes individualized resident care) for information on individual care needs and preferences ..." Resident #3 In an interview on 4/15/24 at 12:43 PM, Resident #3 revealed that some of his grooming is done by staff, with the exception of assisting him in cleaning his teeth. He added that not having his teeth brushed "irritates" him but he has not brought it up. In an interview on 4/17/24 at 9:05 AM, Resident #3, once again emphasized his desire to brush his teeth every day. He explained that his toothbrush and toothpaste were in his nightstand drawer to his right, but he could not reach over to retrieve them. He added that he only needs someone to remove the items from his drawer and place them on the overbed table, as he can brush his own teeth, but staff "have never offered" to help him. Record review of the "Admission Record" revealed Resident #3 was admitted to the facility on 10/16/23. Current diagnoses include Morbid (Severe) Obesity and Muscle Weakness. Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/22/24 revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated Resident #3 was cognitively intact. Resident #6 During an interview on 4/15/24 at 2:11 PM,	F 677	Care Plan an providing toothbrushes and toothpaste to Resident.Education will be completed by 5/10/2024. Oral care will be provided as part of Activities of Daily Living (ADL) personal hygien. Residnt will be provided hygien products on admit and as needed. Resident will have Comprehensive Care Plan that includes measurable objectives and timetables to meet the residents' medical, nursing, mental and psychosocial needs to include personal hygiene. New Hires will be educated during orientation. 4) Quality Monitoring will be conducted starting 4/19/2024 by Director of Clinical Services or Registered Nurse by observation and audit of Activities of Daily Living (ADL) records twice weekly x 4 weeks then weekly for 2 months to ensure Residents have toothbrushes, toothpaste and oral care provided. Findings will be reported to QAPI Committee starting 5/19/2024 then monthly for 3 months.	

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 04/17/2024

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

(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 6	F 677		

Resident #6 revealed he had not received oral care since arriving at the facility in September 2023. He stated staff members promised him a toothbrush and toothpaste last week, but it has yet to arrive.

On 4/16/24 at 12:53 PM, Resident #6 stated in an interview that the CNAs had never approached him about oral care or offered to provide him a toothbrush or toothpaste to brush his own teeth. He denied ever declining this kind of care. He added that he wants to brush his teeth every day.

A record review of the Admission Record for Resident #6 revealed the facility admitted the resident on 9/28/23. Current diagnoses include Lack of Coordination, Stiffness of Joints, and Hemiplegia and Hemiparesis Affecting Right Non-Dominant Side.

A record review of the Quarterly MDS, for Resident #6, with ARD of 4/3/24 revealed a BIMS score of 15, indicating the resident was cognitively intact.

During an interview with the Interim Director of Nurses (IDON) on 4/16/24 at 11:35 AM, she revealed that residents should have the choice of brushing their teeth daily. The Certified Nursing Assistants (CNAs) should do it or let the residents do it themselves. She points out that it is the role of the CNAs to help provide toothbrushes and other dental hygiene supplies.

On 4/17/24, during an interview with CNA #1, she stated that she is occasionally assigned to care for Resident #6. She revealed that this resident has limited mobility and should be assisted with grooming tasks, such as brushing his teeth. She

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 04/17/2024

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

(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 7 confirmed that the resident should be assisted in cleaning his teeth on a daily basis, as this is part of the grooming process for which CNAs are accountable. During a telephone interview on 4/18/24 at 10:33 AM, with the Administrator, she revealed she expects the CNAs to provide "top to bottom" care for residents as needed. The CNAs are to follow their task list when doing care. This means taking care of their hair, nails, and teeth, she wants it all done.	F 677		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and policy review, the facility staff failed to provide treatment and services in a manner to promote the healing and prevent complications of a pressure ulcer for one (1) of four (4) sampled residents with pressure ulcers. Resident #5	F 686	1) Root Cause Analysis was conducted and based on findings Resident #5 was provided wound care following the physician orders on 4/16/2024 by Licensed Nurse. 2) Residents with physician orders for	5/22/24

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 04/17/2024

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

(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 686	Continued From page 8 Findings include: Review of the facility's policy titled, "Skin and Wound," revised 1/24/2, revealed, "Policy: To provide a system for identifying risk, and implementing resident centered interventions to promote skin health, prevention, and healing of pressure injuries ... Process: Pressure Injury Prevention ... 3. Nurse is to complete skin evaluation weekly and prior to transfer/discharge and document in the medical record ... Skin Impairment Identification: 1. Document presence of skin impairment(s)/ new skin impairment(s) when observed and weekly until resolved. 2. Nurse to report changes in skin integrity to physician/physician extender, resident/resident representative and document in the medical record ... On-going Evaluation 1. Evaluate the effectiveness of interventions, and progress towards goals during the standard of care and the care plan meetings ...." On 4/16/24 at 8:43 AM, an interview the Interim Director of Nursing (IDON) stated they have not had a wound care nurse for two weeks, as the wound care nurse resigned. She revealed a Nurse Practitioner (NP) comes on Wednesday and measures the pressure and vascular wounds. The facility has all her assessments uploaded to the resident's computerized chart by the following Monday, so the staff can have access to them. The IDON stated she expects staff to do wound care and chart the care in the resident's chart. On 04/16/24 at 3:45 PM, an observation of wound care for Resident #5 revealed while performing wound care to the resident's sacral wound, Licensed Practical Nurse (LPN) #1 did not apply	F 686	wound care has the potential to be affected. 3) Education with Licensed Nurses conducted on 4/19/2024 by Director of Clinical Services or Registered Nurse on following physician orders when providing wound care. Demonstration and return demonstration competency on providing wound care was conducted with Licensed Nurse on 4/22/2024 by Director of Clinical Services. Residents will have physician orders for wound care and orders will be followed when providing wound care to ensure treatment and services are provided in a manner to promote healing and prevent complications of pressure ulcer. New hires will be educated in orientation. 4) Quality Monitoring will be conducted starting 4/18/2024 by Director of Clinical Services or Registered Nurse twice weekly x 4 weeks the weekly for 2 months to ensure wound care orders are followed when wound care is provided to ensure treatment and services are provided in a manner to promote healing and prevent complications. Findings will be reported to QAPI Committee starting 5/19/2024 and monthly times 3 months.	

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 04/17/2024

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

(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 686	Continued From page 9	F 686		

the Dakins moist dressing to the wound bed prior to covering the wound with foam border gauze.

Record review of the "Order Summary Report," with active orders as of 4/17/24 revealed an order dated 2/9/24 "Wound Care: Clean unstageable pressure wound to Sacrum, with full strength Dakins, Place Dakins moist gauze to wound bed, cover with foam brooder (boarder) gauze every day shift ..."

On 4/16/24 at 4:28 PM, in an interview regarding the wound care, of Resident #5, Licensed Practical Nurse (LPN) #1 confirmed that she did not apply the Dakins moist gauge to the wound bed prior to covering the wound with the border gauze. The nurse stated the physician's orders for wound care are written to aid in the healing of the wound and should be followed.

On 4/16/24 at 4:40 PM, in an interview with the IDON, she confirmed that LPN #1 should have followed physician orders, as the moist dressing aids in healing the wound. The IDON added that by not following the physician's orders, there is a possibility the wound could get worse.

Review of the "Admission Record," revealed Resident #5 was admitted to the facility on 8/9/21.Current diagnoses include Alzheimer's Disease, Type 1 Diabetes Mellitus, and Atherosclerotic Heart Disease.