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 12/11/2024

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 two (2) Complaint Investigations (CI MS #27064 and CI MS #27213), at the facility from 12/11/24 through 12/12/24. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid for CI MS #27213 and cited F550 for resident rights and F585 for unresolved grievances. The SA did not find deficient practice for CI MS#27064. The census at the time of the survey was 59 with a license for 66 beds.	F 000		
F 550 SS=E	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 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	F 550		1/16/25

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

Electronically Signed | 12/27/2024

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 _____	C 12/11/2024

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 550	Continued From page 1 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 staff and resident interviews, record review, and facility policy review, the facility failed to honor a resident's right to be treated with dignity and respect for two (2) of four (4) residents reviewed for resident rights. Resident #1 and #3 Findings include: Record review of the facility policy titled, "Resident Rights", dated 7/24/23, revealed, "Employees shall treat all residents with kindness, respect, and dignity. ... 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence; b. be treated with respect, kindness, and dignity". Resident #1	F 550	1. On 12/12/2024, Resident #1 was assessed by the Administrator and DON for any negative outcomes of the incident. Resident #1 was pleasant, happy and showed no signs of distress. On 12/12/2024, Resident #3 was assessed by the Administrator and DON for any negative outcomes of the incident. Resident #3 was pleasant, happy and showed no signs of distress. Beginning 12/12/2024, the facility will ensure that all alleged allegations involving abuse, neglect, exploitation, mistreatment, violations of resident rights and/or the exercise of rights including injuries of unknown origin and misappropriation of resident property will be reported immediately to Administrator and Director of Nursing (DON). The Administrator 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 _____	C 12/11/2024

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 550	Continued From page 2 During an interview on 12/11/24 at 11:50 AM, Resident #1 stated there was an incident where she was made to feel like a "nobody" and was pushed in her wheelchair by Registered Nurse (RN) #1. She stated she was putting the phone back at the nurses' station and was speaking to the Dietary Manager when RN #1 came up and told her, in a very rude way, to get out of that area because only staff were allowed there and then pushed her wheelchair with force. Resident #1 stated she told RN #1, "Don't push me and don't touch me or my chair!". She stated she also told RN #1 that if the rules were changed, they needed to inform the residents since she had been going behind the desk to use the phone since she had been in the facility. She revealed she continued by telling RN#1 that this was her home and not a prison. She stated she was not physically harmed but felt upset that she was scolded like that. An interview with the Dietary Manager on 12/11/24 at 1:45 PM confirmed she was at the nurses' station when the incident between Resident #1 and RN #1 occurred, and she reported this to the social worker. She confirmed that Resident #1 was returning the phone to the desk and RN #1 came up and told her she could not be back there. She stated that the resident told RN#1 that she was just putting up the phone and RN#1 said you cannot be behind the desk. She revealed that RN#1 squeezed between Resident #1's chair and the nurses' station wall which might have pushed Resident #1's chair, but she did not see RN #1 intentionally push the chair. She stated the resident was "visibly upset" and said she felt like "a prisoner" and that she had rights, then rolled back to her room. She	F 550	DON will then immediately report allegations to the State Agency and all appropriate agencies within the appropriate time frame. All allegations will be investigated by the Administrator and/or DON and a report of the full investigation will be sent to the State Agency and all appropriate agencies upon conclusion with corrective actions. Newly hired staff will be educated in orientation regarding Resident Rights and how to report any violation of Resident Rights immediately to appropriate parties. 2. All residents have the potential to be affected by the alleged deficient practice. 3. The DON began in-service of present staff on Resident Rights and how to report any violations of Residents Rights on 12/11/2024 and concluded in-service training on 12/12/2024. The DON will continue to train/in-service as needed thereafter with present and future staffing. 4. All allegations of violations of Resident Rights will be thoroughly investigated by the Administrator and/or DON. Social Services will continue to oversee the Grievance Process and will report any Resident Rights grievances to the Administrator or DON immediately for investigation. On 12/12/2024, the Social Services Director began reporting all grievances to the Administrator daily in stand-up meetings to ensure facility compliance with reporting allegations. The Administrator will interview a sample of 5 residents, including Resident #1 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 _____	C 12/11/2024

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 550	Continued From page 3 stated she understood why the resident was so upset since this was her home and she had every right to use the phone. She stated that RN#1 was not yelling but the way it came out did sound rude and should have been worded differently. During a phone interview on 12/11/24 at 4:45 PM, RN#1 confirmed she upset Resident #1 and stated that she never meant to hurt Resident #1's feelings or to make her feel bad in any way. She stated she was speaking to the staff and not directly to the resident to remind staff of the confidential information that had to be protected. She stated she did not push the resident, and the resident propelled herself to her room. She revealed she did not realize there was a concern until she was told that Resident #1 was upset so she and the Director of Nursing (DON) went to apologize immediately. She stated she realizes now that even though she was not speaking directly to the resident, the resident was there and heard everything that was said. She admitted that it was not respectful to speak about that when the resident was there and knew she was the one being talked about. She stated that each resident should be treated with dignity and respect and even though she did not mean to upset the resident, she could see how that situation caused Resident #1 to be upset with hurt feelings. During an interview on 12/12/24 at 9:45 AM, Certified Nursing Assistant (CNA) #1 stated she was at the nurses' station when Resident #1 came to return the phone and was speaking to the Dietary Manager. She confirmed that she heard RN #1 tell Resident #1 that she could not be behind the desk, and she needed to get out from behind there. She stated that RN#1 did not yell, but had a blunt, stern, and matter of fact	F 550	Resident #3, in the facility weekly beginning 12/13/2024 for 12 weeks to ensure all residents are safe from violations of Resident Rights. The Administrator will report findings to the Quality Assurance and Performance Improvement Committee on 1/7/2025 and monthly for 3 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 _____	C 12/11/2024

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 550	Continued From page 4	F 550		

tone. She stated she was charting and did not see RN#1 push her chair. She confirmed that the resident was upset and angry about the incident.

An interview with the Administrator on 12/12/24 at 10:45 AM confirmed each resident had the right to be treated with dignity and respect. She confirmed the facility failed to ensure that Resident #1's rights were honored when she felt she was scolded and reprimanded by a staff member.

Record review of Resident #1's "Admission Record" revealed the facility admitted her on 1/16/24 with medical diagnoses that included Multiple Sclerosis and Systemic Lupus Erythematosus.

Record review of Resident #1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/7/24 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated this resident was cognitively intact.

Resident #3

During a record review of the Resident Council Meeting minutes, it was revealed that during the meeting on 11/26/24 there was a concern involving Resident #3. The entry on the Resident Council minutes sheet read as follows: "(Resident #4) let us know that a nurse assistant was ugly to (Resident #3) on 11/23/24 while the residents were watching the Alabama football game...I met with DON alongside (Administrator) to report the issue. They stated they would open an investigation and talk with the CNA (Certified Nursing Assistant). Resident #4 said the aid told Resident #3 she was tired of dealing with him".

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 12/11/2024

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 550	Continued From page 5	F 550		

This was signed by the Activity Director on 11/26/24.

An interview with the Activity Director on 12/11/24 at 12:15 PM confirmed that during the Resident Council meeting on 11/26/24, Resident #4 was asked by Resident #3 to tell of the incident that occurred. She stated Resident #4 said that he and Resident #3 were watching a football game in the dining room and a CNA was rude to Resident #3 telling him that she "was tired of working with him". She stated that while Resident #4 was telling of the incident that had occurred, Resident #3 was teary eyed. The Administrator was in the meeting with her, and they both went and reported it to the Director of Nursing and was told it would be investigated.

During an interview on 12/11/24 at 1:30 PM, Resident #4 confirmed that he witnessed an incident where a CNA was rude to Resident #3. He stated he does not know which CNA it was. He stated this occurred during the Alabama football game on Saturday 11/23/24 and he and Resident #3 were in the dining area watching the game. Resident #3 was leaning in his chair, and he went to get staff because he was concerned Resident #3 would fall. The CNA told Resident #3 something like she was "damn tired of doing this s**t" and this upset Resident #3. He stated that the next evening, Resident #3 came to him and was still upset asking if he would mention this in the next Resident Council meeting. He stated he was not sure what the facility did for this situation, but he knew they were aware it happened.

An interview with Resident #3 on 12/11/24 at 1:40 PM, confirmed that he was in the dining room

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 12/11/2024

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 550	Continued From page 6	F 550		

watching a football game and was needing a pillow so Resident #4 went to get the staff. He thought it was CNA #2 that came to check on him and he asked her for a pillow, and she said, "No, you don't need that pillow" and "I'm tired of doing this" and did not get it for him. He stated she did not cuss at him, but it did upset him, and he thought, "Woah, oh no, that's not good" and "she should help". He stated it did upset him, that he needed something to help him be more comfortable and that care was denied. He stated it was rude and disrespectful and not sure if abusive, but it was not right and it did "make me get pretty down and upset". He confirmed that Resident #4 witnessed this and the next day after the incident he was still bothered about it and asked Resident #4 to mention it in the Resident Council meeting since he did not feel comfortable talking about it.

During a phone interview on 12/11/24 at 4:00 PM, CNA #2 revealed she was at the desk and Resident #4 came to the desk and said something was wrong with Resident #3 because he was leaning and falling from his chair. She revealed that she went to the dining room and there was no concern with Resident #3's position. She revealed that she thought Resident #3 was upset due to a phone conversation with his mother and not her or the care. She stated she did not tell the resident she was tired of caring for him and would not say that to any resident.

An interview with the Administrator on 12/12/24 at 10:45 AM revealed she was aware of what was reported regarding a CNA being ugly to Resident #3 because it was reported in the Resident Council, and she was in the meeting. She stated she and the Activity Director informed the 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 _____	C 12/11/2024

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 550	Continued From page 7 of Nursing who spoke with the staff involved and could not determine whether any abuse occurred. She stated that the staff interviewed told her that Resident #3 was upset since it was Thanksgiving time, and his mother had changed the date she was going to pick him up. She stated after speaking to the two staff members, she felt there were no concerns since she was told he was only upset because his mother was not going to pick him up for Thanksgiving. Record review of Resident #3's "Admission Record" revealed the facility admitted the resident on 11/3/23 with medical diagnoses that included Cerebral Palsy. Record review of Resident #3's MDS with an ARD of 10/11/24 revealed a BIMS score of 14 which indicated this resident was cognitively intact.	F 550		
F 585 SS=E	.. Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.	F 585		1/16/25

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 12/11/2024

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 585	Continued From page 8	F 585		

§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations

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 12/11/2024

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 585	Continued From page 9	F 585		

by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and
(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than

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 12/11/2024

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 585	Continued From page 10 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on staff and resident interviews, record review, and facility policy review, the facility failed to make prompt efforts to resolve and thoroughly investigate grievances from Resident Council meetings for eight (8) of the last nine (9) Resident Council meetings. Findings include: Record review of the facility policy titled, "Grievances and Complaints" dated 2/14/23, revealed, "Social Services will act as the grievance officer for the facility and oversee the grievance process. Grievance forms should be kept outside of the office, where residents, family members, and staff members can access them at any time. All grievances will be reported to Social Services and Social Services will follow the following procedure to investigate and work to resolve the grievance. Step 1 Upon receipt of a grievance, Social Services will complete a written report within 5 working days of the filed grievance and determine what corrective actions, if any, should be taken ...Step 2 Social Services must notify the person who filed the grievance, within 10 working days of the filed grievance, in the form of a report ..." During a record review of the Resident Council Minutes, it was revealed that during the meeting on 11/26/24 there was a concern involving Resident #3. The entry on the Resident Council Minutes sheet read as follows: "(Resident #4) let us know that a nurse assistant was ugly to (Resident #3) on 11/23/24 while the residents	F 585	1. The facility will ensure that all grievances and complaints are documented, investigated, and reported according to facility policy titled, Grievances and Complaints dated 2/14/2023. Social Services has been acting as the grievance officer for the facility and overseeing the grievance process since 2/12/2024. Grievance forms should be kept outside the office, where residents, family members, and staff members can access them at any time. All grievances will be reported to Social Services and Social Services will follow procedures to investigate and work to resolve the grievance. Upon receipt of a grievance, Social Services will complete a written report within 5 working days of the filed grievance and determine what corrective actions, if any, should be taken. If the grievance is related to any form of abuse or harassment, the administrator must be notified immediately. Social Services must notify the person who filed the grievance, within 10 working days of the filed grievance, in the form of a report. Copies of this report will be available to the person filing the grievance at any time. If the filer is not satisfied with the results of the investigation, the filer will be advised to file a report with the local ombudsman. The contact information for the local ombudsman is easily accessible and visible in the facility. The Grievance Process was reviewed with residents in	

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 12/11/2024

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 585	Continued From page 11 were watching the Alabama game... I met with DON (Director of Nursing) alongside (Administrator) to report the issue. They stated they would open an investigation and talk with the CNA (Certified Nursing Assistant). Resident #4 said the aid told Resident #3 she was tired of dealing with him". This was signed by the Activity Director on 11/26/24. The record review of Resident Council Minutes revealed repeated concerns with staff's use of cell phones in the facility was a mentioned during the meetings held on 9/5/24, 9/11/24, 9/18/24, 9/26/24, 11/14/24, and 11/26/24. The concern for the staff turning call lights off and not providing requested care unless they were assigned to that resident was voiced during the meetings on 8/14/24, 9/5/24, 11/14/24, 11/26/24, and 12/5/24. Repetitive concerns of bed sheets not being changed were voiced on 7/24/24, 8/14/24, 9/5/24, 9/11/24, 9/18/24, 9/26/24, and 10/9/24. During an interview on 12/11/24 at 11:50 AM, Resident #1 revealed she attended the Resident Council meetings regularly. She stated there are grievances that continued to be a concern even though they were mentioned in the meetings often. She stated one of these areas was that some of the Certified Nursing Assistants (CNA) did not assist her with care unless they were assigned to her. She stated they say things like "they don't have her" and "they will let her CNA know" and that delayed receiving the needed care. She also stated another frequent grievance was that some staff were on their phones often and if they had time for that, they should have time to provide the care requested. An interview with the Activity Director on 12/11/24	F 585	the Resident Council meeting on 12/27/2024. 2. All residents have the potential to be affected by the alleged deficient practice. 3. Repeated concerns with the staff□s use of cell phones in the facility: In-service of cell phone usage in facility was conducted on 12/18/2024. This in-service covered Cellular Phones, Laptops, and Tablets policy dated 1/31/2018. Repeated concerns for staff turning call lights off and not providing requested care unless they were assigned to that resident: Director of Nursing (DON) conducted in-service and staff meeting with staff on 12/18/2024 to train and coach that all employees are here to assist all residents, regardless if they are assigned to that resident□s care for the day. Repeated concerns of bed sheets not being changed: all linens are changed on bath day either Monday, Wednesday, Friday, or Tuesday, Thursday, Saturday. Bed linens are also changed daily, as needed. The DON began in-service of present staff on Resident Rights and how to report any violations of Resident Rights on 12/11/2024 and concluded in-service training on 12/12/2024. The DON will continue to train/in-service as needed thereafter with present and future staffing. 4. Resident Council will meet weekly starting 12/27/2024 for 8 weeks and then monthly. The Administrator will review Resident Council Minutes weekly to ensure all repeated concerns are	

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 12/11/2024

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 585	Continued From page 12 at 12:15 PM confirmed that during the Resident Council meetings, residents had voiced grievances which included the staff being on their phones and the staff only providing care for the residents they were assigned to. She stated the grievances in the Resident Council meetings were listed on the meeting minutes form and were provided and signed off by each department so the concerns could be addressed and resolved. She stated part of the grievance process was to make sure the staff in the area of concern was aware so a solution could be implemented. Activity Director confirmed that during the Resident Council meeting on 11/26/24, Resident #4 was asked by Resident #3 to tell of the incident that occurred. She stated Resident #4 said that he and Resident #3 were watching a football game in the dining room and a CNA was rude to Resident #3 telling him that she "was tired of working with him". The Administrator was in the meeting with her, and they both went and reported it to the Director of Nursing and was told it would be investigated. On 12/11/24 at 1:30 PM, dduring an interview, Resident #4 revealed he witnessed an incident where a CNA was rude to Resident #3. He stated he does not know which CNA it was. He stated this occurred during the Alabama football game on Saturday 11/23/24 and he and Resident #3 were in the dining area watching the game. He stated he was not sure what the facility did for this situation, but he knew they were aware it happened. An interview with the Administrator on 12/12/24 at 10:45 AM confirmed the facility failed to address the recurring grievances in Resident Council meetings concerning phone use by staff and staff	F 585	resolved. The Administrator will continue to monitor and review Resident Council Minutes monthly from here and thereafter. The Administrator will report findings to the Quality Assurance and Performance Improvement (QAPI) Committee monthly. Repeated concerns with the staff□s use of cell phones in the facility, repeated concerns for staff turning call lights off and not providing requested care unless they were assigned to that resident, and repeated concerns of bed sheets not being changed bed linens will be monitored by DON 5 times (x) weekly for 4 weeks and then 1x weekly for 2 months beginning 12/12/2024. Any findings will be addressed and corrected immediately. All findings will be reported to the Administrator weekly for 3 months. The Administrator will report findings to the QAPI Committee monthly for 3 months beginning 1/7/2025.	

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 12/11/2024

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 585	Continued From page 13	F 585		

not providing care for residents assigned to another staff member. She was aware of what was reported in the Resident Council meeting concerning Resident #3 since she was in the meeting. She stated she and the Activity Director informed the Director of Nursing that it was mentioned in resident council that Resident #3 had been talked to in a mean way and was denied care. She reported back to me that she had spoken with the staff involved and could not determine that any abuse had occurred. She informed me that the staff told her that Resident #3 was upset after a phone call to his mother. She stated after speaking to the two staff members, she felt there were no concerns since she was told he was only upset because his mother was not going to pick him up for Thanksgiving. She revealed the facility failed to develop a plan to correct the concerns and keep residents informed of the process towards a resolution. She admitted there had been concerns voiced in Resident Council meetings that had not been resolved and the residents were not informed of the steps taken to resolve the grievance. She stated any grievance should be investigated and steps should be taken to resolve the concern.

Record review of Resident #1's "Admission Record" revealed the facility admitted her on 1/16/24.

Record review of Resident #1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/7/24 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated this resident was cognitively intact.