STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255145	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD HEALTH AND REHABILITATION	**501 SOUTH LOCUST STREET , MCCOMB, Mississippi, 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
F0000	INITIAL COMMENTS The State Agency (SA) conducted a complaint survey at the facility for Complaint #258588, Incident #2588965 and Incident #2584981 from 8/11/25 through 8/13/25. The SA investigated Complaint 258588 for abuse with no deficiencies cited. The SA investigated Incident #2588965 for quality of care with no deficiencies cited. The SA investigated Incident #2584981 and cited F689 at level Immediate Jeopardy (IJ) as Past Noncompliance (PNC) and determined during the survey, based on implementation of corrective actions, the facility was in compliance with the requirements for participation in Medicare and Medicaid. The SA identified Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC), Past Noncompliance, that began on 8/07/25 when facility staff failed to provide supervision for Resident #1 resulting in the elopement of the resident. The facility's failure to ensure supervision and implement interventions—including failure to detect the resident's absence promptly and failure to secure exit doors—resulted in Resident #1 exiting the facility through the front entrance without staff knowledge and being unsupervised in the community for approximately one (1) hour and twenty-nine (29) minutes. The resident was found approximately two (2) miles away at a local business after receiving a ride from an unknown individual. This failure placed Resident #1 in a situation that was likely to cause serious injury, serious harm, serious impairment, or death, given the resident's severe cognitive impairment, multiple medical diagnoses, and the environmental risks encountered during elopement (e.g., traffic, extreme heat, lack of supervision). IJ and SQC existed at: CFR 483.25(d)(2) Accidents/Hazards - F689 - Scope/Severity "J" The facility Administrator was notified of the IJ and SQC on 8/11/25 at 4:15 PM and was presented with the IJ Templates. Based on the facility's implementation of corrective	F0000		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0000	Continued from page 1 actions on 8/8/25, the SA determined the IJ and SQC to be Past Non-Compliance (PNC) and the IJ was removed on 8/9/25, prior to the SA's entrance on 8/11/25. The SA validated the Corrective Action Plan on 8/13/25 and determined that the IJ was removed on 8/09/25, prior to SA entrance on 8/11/25. The facility had a license for 145 beds, with a census of 112 residents.	F0000		
F0689 SS = SQC-J	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 observation, interview, record review, and facility policy review, the facility failed to provide supervision and implement effective elopement prevention strategies for one (1) of four (4) sampled residents (Resident #1), who had a known cognitive impairment and elopement risk, resulting in an incident of elopement. The facility's failure to ensure supervision and implement interventions—including failure to detect the resident's absence promptly, and failure to secure exit doors—resulted in Resident #1 exiting the facility through the front entrance without staff knowledge and being unsupervised in the community for approximately one (1) hour and twenty-nine (29) minutes. The resident was found approximately two (2) miles away at a local business after receiving a ride from an unknown individual. This failure placed Resident #1 in a situation that was likely to cause serious injury, serious harm, serious impairment, or death, given the resident's severe cognitive impairment, multiple medical diagnoses, and the environmental risks encountered during elopement (e.g., traffic, extreme heat, lack of supervision).	F0689	"Past Noncompliance - no plan of correction required"	

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F0689 SS = SQC-J	Continued from page 2 The facility's failure to ensure supervision and implement interventions for Resident #1, who was an elopement risk, put this resident and all other residents at risk for wandering and elopement, at risk for serious injury, serious harm, serious impairment, or death. This situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC), which began on 08/07/2025, when Resident #1 exited the facility unsupervised and without authorization. The State Agency (SA) notified the Administrator of the Immediate Jeopardy on 08/11/2025 at 4:15 PM and provided an IJ Template. The State Agency (SA) validated the Corrective Action Plan on 8/13/25 and determined that the IJ was removed on 8/9/25, prior to exit. Findings include: Record review of the facility policy titled, “Missing Patient/Resident” with Revision Date 8/01/2020 revealed, “OVERVIEW: Staff will investigate cases of missing patient/resident and possible elopement. An elopement occurs when a patient/resident leaves the premises or a safe area without authorization and/or any necessary supervision to do so, placing the patient/resident at risk for harm or injury…” Record review of the facility policy “Accident and incident Investigation” with Effective Date 11/30/2014 revealed, “Policy: Certain Accidents and Incidents…will be investigated to determine root cause and provide for opportunity to decrease future occurrences of the event…” Record review of the facility policy “Elopement/Wandering Risk Guideline” with Revision Date 8/01/2020 revealed, “Overview: To evaluate and identify patient/residents that are at risk for elopement and develop individualized interventions…” Record review of the Incident Report dated 8/07/25 revealed documentation of the elopement and return without injury of Resident #1 on 8/07/25. Record review of the facility “Verification of Investigation” dated 8/07/25 revealed on 8/7/25 at 11:10 AM the nurse discovered Resident #1 was unable to be located. Facility staff called a “Code Yellow” and searched for the resident. The local police department and the Resident Representative (RR) were notified. At 11:53 AM the local police department notified the	F0689		

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F0689 SS = SQC-J	Continued from page 3 facility the resident had been found. At 12:05 PM, the Resident returned to the facility and was assessed by the Nurse Practitioner with no injury noted. On 8/11/25 at 10:10 AM, during a record review of the Facility Investigation and Incident Report both dated 8/7/25 and an interview with the Administrator and the Director of Nursing (DON), revealed the DON reported that the elopement of Resident #1 was discovered when Licensed Practical Nurse (LPN) #1 realized she no longer saw the resident sitting in the lobby where he had been last observed at or around 10:30 AM. The DON reported that she was on D Hall at approximately 10:45 AM when LPN #1 reported to her that she was unable to locate Resident #1. The DON immediately notified the Administrator at approximately 11:10 AM. At approximately 11:15 AM the DON notified the Administrator and called a “CODE YELLOW” using the overhead public announcement (PA) system. They reported that the resident was last seen seated in a chair in the lobby facing the reception desk and main entrance at approximately 10:30 AM in the lobby across from the front door. The DON and Administrator both said that in separate interviews with the resident upon return to the facility he had told them that he left the facility through the front door when visitors were coming in/going out. The Administrator and DON both confirmed that the resident was last observed in the facility at approximately 10:30 AM and was out of the facility unattended by staff for approximately one hour and twenty-nine minutes when he was observed at a local laundromat two (2) miles from the facility with no obvious injury. They explained that the system of how staff was made aware of a missing resident included word of mouth and “Code Yellow” announced over the overhead PA system. They explained that they call the alert anytime a resident couldn’t be located and hadn’t signed out using the alert,” Code Yellow” which was called at 11:20 AM on 8/07/25. The Administrator confirmed the report by the DON that the Administrator had been notified of a missing resident at 11:15 AM on 8/07/25 after the DON was notified at approximately 11:10 AM, and the Resident Representative for Resident #1 was called at 11:24 AM but the telephone number was out of service and the DON called the resident’s daughter at 11:26 AM, and the NP for the resident’s physician was notified at 11:20 AM. The DON said that she had conducted a body audit and found no injuries and the NP completed an assessment and noted no injuries and the resident was not transferred to the hospital. They said the immediate response of the facility was that the staff searched for resident, the resident was returned to the facility via Unit Manager, the NP was present at the facility upon the resident’s	F0689		

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F0689 SS = SQC-J	Continued from page 4 return and assessed resident, which included a Body Audit, and finally one-on-one supervision was provided for Resident #1 for 48 hours and a wander guard anklet was applied to the resident's ankle immediately. The DON and Administrator said the police were notified, but during interview in the Administrator's office, The Unit Manager notified the resident had been located and was in route back to the facility at 11:46 AM, so they were not sure if a police report was written or not. The DON reported that elopement was reported to the State Agency on 8/07/25 at 1:28 PM. They reported that the Maintenance Supervisor checked the security of the doors at 1:00 PM on 8/07/25 as well as every day shift, Monday through Friday, and the residents' wander guard units were checked by the nurses as well as each night. The DON reported that she conducted Missing Resident/Elopement Drills every three months (quarterly) by DON in accordance with facility policy. The DON reported that In-Service Training for all staff was started on 8/07/25. The DON confirmed that the facility did routine audits to ensure elopement books and daily care guides were accurate. The Administrator and DON confirmed that a Census Audit was conducted, and the presence of all other residents not signed out was confirmed via direct observation by the nursing staff. The DON and record review of the Care Plan for Resident #1 revealed that Resident #1's care plan was revised/updated after the elopement on 8/7/25. On 8/11/25, the SA attempted multiple times to contact the RR and Contact #1 for Resident #1 without success and no mechanism to leave a message. On 8/13/25 during a telephone interview with Contact #1 for Resident #1, his family member confirmed that the facility had notified her on 8/07/25 that Resident #1 had eloped and that he had been returned to the facility. On 8/11/25 at 10:25 AM, observation and an interview with Resident #1 in his room revealed Resident #1 stated that he was from a nearby town where his family lived, approximately twenty-five miles away. He confirmed that he had eye surgery which had greatly improved his vision. He stated that he was able to get himself up and walk with his cane but used his wheelchair for longer distances. He said he remembered on 8/07/25 going out the front main entrance and "getting a ride" with a man in a truck to a nearby avenue. He stated that his ultimate goal was to get to his former residence. He said that the man in the truck dropped him off at the local business and that facility staff had "shown up" and given him a ride back to the facility. Observation revealed the resident had a wander guard safe wandering device on his left ankle.	F0689		

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F0689 SS = SQC-J	Continued from page 5 On 8/11/25 at 10:45 AM, during an interview LPN #1 stated she observed Resident #1 walking with a walker, and that he had taken a seat in the lobby across from the reception desk and main front entrance at approximately 10:00 AM wearing a black sock cap, a short-sleeved button up shirt, a pair of blue jeans and slide on shoes, holding his cane. She stated that at approximately 10:50 AM, she had begun to look for him and he was no longer sitting in the lobby, nor was he in the dining room or common areas and was not in his room. She said that after looking in those areas, at approximately 11:00 AM she notified the DON that she could not locate the resident, the DON called a “Code Yellow” over the PA system and staff continued to look inside and outside for the resident. She reported that notifications were made to the resident’s primary healthcare provider (PHP), Contact #1 and local police department (PD). She stated that the PD sent out an officer but that shortly after the officer arrived, RN #1 (Unit Manager) notified the DON that she (RN #1) had located the resident and had him in her supervision and was returning to the facility with him. She stated that the PHP was present at the facility upon his return so Registered Nurse (RN) #1 and the PHP conducted assessment including body audit and identified no injuries and the resident’s vital signs were all within normal limits. She stated she had not observed any change in physical or psychosocial condition since the elopement. She stated that the weather was clear and hot on 8/07/25. She stated that during the missing resident procedure, CNA #1 had reported to her that she (CNA #1) had last seen Resident #1 in the facility at approximately 10:45 AM in the lobby and noted no agitation or unusual behavior. LPN #1 reported that upon return to the facility at 11:59 AM the resident was immediately placed on one-on-one supervision for forty-eight (48) hours, and a safe wandering device was applied to his left ankle and tested for proper functioning. She confirmed that on 8/07/25 the facility provided in-service training regarding resident rights, abuse and neglect prevention and reporting, resident safety and facility protocol/procedures for safe wandering, missing residents and elopements on 8/07/25. LPN #1 stated that Resident #1 had never displayed exit seeking behavior prior to 8/07/25. On 8/11/25 at 11:00 AM, an interview with the facility Receptionist revealed she recalled that on 8/07/25 at approximately 11:10 AM, Resident #1 had approached the sliding glass window of her office walking with his cane and expressed that he needed to go home and see his family. She stated that he had developed a habit of visiting the Reception Desk and requesting cash and that he was usually in his wheelchair. She said she	F0689		

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F0689 SS = SQC-J	Continued from page 6 asked him to take a seat as she was busy with cash disbursements, answering telephone calls and granting entrance and exit for staff, contractors and visitors. She stated that she had not observed him get up or leave the lobby. She confirmed that the facility provided in-service training regarding resident rights, abuse and neglect prevention and reporting, resident safety and facility protocol/procedures for safe wandering, missing residents and elopements on 8/07/25. On 8/11/25 at 11:10 AM, observation revealed all parking spaces in the well-maintained facility parking lot surfaced with asphalt. Observation revealed the route to the location where Resident #1 was located lead through a well populated residential area, over a bridge that was over a railroad track and led to a four-lane avenue with a speed limit of thirty-five (35) miles per hour, with repaving in progress and several traffic lights and pedestrian walkways; the location was equal distance between two traffic lights. The location where the resident was located by RN # 1, was a local business with a deep parking lot surfaced with well-maintained concrete, four occupied parking spaces and five unoccupied and one main entrance. The SA observed one hundred fifty (150) cars traveling the avenue in front of the location in a five-minute period. Review of weather history for the locale for 8/07/25 per world wide web national weather service revealed that on 8/07/25 at 11:53 AM the temperature was eighty-nine (89) degrees Fahrenheit with six (6) mile per hour winds and zero (0) precipitation and conditions were partly cloudy. On 8/11/25 at 1:10 PM, an interview revealed RN #1 she observed Resident #1 sitting in the lobby at around 11:10 AM time when she left going to the hospital to take a sample to the laboratory. She stated that returning to the facility she was driving west on the boulevard and observed the resident wearing a black knitted hat, short-sleeved button-up shirt, slide on shoes and carrying a cane walking through the parking lot of a local business in a parking space near the business' door. She stated she had parked her car near the front door, got out and assisted the resident without resistance into the backseat of her car. She described the weather as partly cloudy and hot. She reported that during the drive back to the facility the resident told her that he exited the facility through the front door and got a ride with a man in a truck to the location where she located him. RN #1 confirmed that the facility provided in-service training regarding resident rights, abuse and neglect prevention	F0689		

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F0689 SS = SQC-J	Continued from page 7 and reporting, resident safety and facility protocol/procedures for safe wandering, missing residents and elopements on 8/07/25. On 8/11/25 at 4:05 PM interview with CNA #1 revealed she said was working dayshift on D Hall on 8/07/25 and was assigned to the care of Resident #1. She said she had observed him sitting in a chair holding his cane in the front lobby across from the front office and front entrance at approximately 8:45 AM. She reported that at approximately 11:15 AM she did not observe the resident anymore until he returned from elopement. Record review of the Ad Hoc Quality Assurance and Performance Improvement (QAPI) dated 8/08/25 with attached sign-in sheet revealed confirmed that the facility conducted a QAPI committee meeting attended by the Medical Director, DON, Infection Preventionist (IP) and other key personnel/department directors. The agenda included the elopement of Resident #1 on 8/07/25 with a plan for the prevention with corrective actions included. Record review of the Education In-Service Attendance Record dated 8/07/25 with attached sign in sheet confirmed the facility provided in-service training for all staff regarding the facility elopement policy and procedure for missing residents and missing resident procedure experience. Record review of the Education In-Service Attendance Record dated 8/07/25 with attached sign in sheet confirmed the facility provided in-service training for all staff regarding visualization of the door until it is clear and closed and locked when granting admission/egress and abuse and neglect prevention and reporting. Record review of the Admission Record for Resident #1revealed the facility admitted the resident on 9/27/24 and the resident had diagnoses of osteoarthritis, hypertension, vision loss, and atherosclerotic heart disease. Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date of 7/4/25 revealed Resident #1 had a Brief interview for Mental Status (BIMS) score of 3, which indicated severe cognitive impairment. Section B indicated the facility had assessed the resident having severely impaired vision and Section GG indicated that he relied on a wheelchair for mobility. Corrective Action Plan: Brief Summary of Events:	F0689		

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F0689 SS = SQC-J	Continued from page 8 On 8/11/25 at 4:15 PM the State Agency (SA) notified the Executive Director (ED) of an immediate jeopardy Past Noncompliance related to F 689 Free of Accident Hazards /Supervision /Devices. Resident #1 at approximately 10:30 am left out the front entrance door and exited facility without staff knowledge. Resident #1 was located at 11:56 am approximately 2.0 miles from facility by Licensed Nurse #1 who returned the resident to the facility where he was assessed by nursing staff and his primary healthcare provided with no injuries noted and he was fitted with a safe wandering device. Immediate Action was initiated on 8/7/25: • At approximately 11:05 AM Licensed Practical Nurse (LPN) #1 and Certified Nurse's Aide (CNA) #1 performed cursory search for resident #1. • At 11:10 AM LPN #1 notified Director of Nursing (DON) that Resident #1 could not be located and the DON notified the Executive Director (ED) at approximately 11:15 AM. • At 11:15 AM DON announced "Code Yellow" using the overhead public announcement (PA) system, for missing resident was called, and staff were dispersed to search inside and outside for Resident #1. • At 11: 14 100% audit completed by Unit Manager #1 and Wound Care to ensure all residents were in the facility and accounted for. • At 11:20 AM Nurse Practitioner (NP) #1 and Resident's Physician were notified of elopement. • At 11:26 AM Resident #1's Contact (daughter) was notified of elopement. • At 11:46 AM the DON notified the local police department of the missing resident. • At 11:48 AM neighboring police department was notified of Resident #1 home address for a well check. • At 11:56 AM Registered Nurse (RN) 1 located Resident #1 approximately 2.5 miles from facility at 11:59 AM and transported Resident #1 back to the facility and arrived at 12:05 PM. • At 12:05 PM NP #1 assessed Resident #1 with no injury noted. A body audit was completed. LPN #1 conducted a	F0689		

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F0689 SS = SQC-J	Continued from page 9 body audit with no noted injury. Resident #1 was interviewed by the DON and ED. Resident #1 stated he had exited the facility through the front door and “an older man in a truck gave me a ride “. The facility initiated one-on-one supervision for Resident #1 for forty-eight (48) hours. • Social Services Director SSD) assessed Resident #1 for psychosocial distress and noted none and completed a new Brief Interview for Mental Status (BIMS) assessment. • At 12:30 PM Director of Nursing obtained an order for Resident #1 to have a secure care bracelet placed and LPN #1 applied secure care bracelet to Resident #1’s Left ankle. The Minimum Data Set (MDS) Nurse updated the Care Plan for Resident #1. • At 1:00 PM the Maintenance Director checked all the exit doors and ensured they were closed and locked. • At 1:28 PM the ED notified the State Ombudsman. • At 1:28 PM DON called the State Agency (SA) hotline and reported the elopement. • At 2:30PM the ED placed signage on door that reminded visitors and staff to ensure door was completely closed when entering and leaving. A sign was also placed on the front desk by the visitors’ sign in book. • At 2:45 PM SSD was notified of need to send out letter to families to re-educate them on the importance of out-on-pass and sign-out procedures, not escorting residents outside of the facility without a staff member present, and encourage them to notify a staff member immediately, if a resident was attempting to leave the facility unattended by staff. • At 4:19 PM DON completed the complaint e-form for the Mississippi State Attorney General. • At 5:00 PM Nurse Managers completed a 100% audit of all residents for elopement risk, checked orders for secure care bracelets, made sure care plans were in place, and assessed residents to ensure those who are elopement risk had secure care bracelets in place and working by testing with handheld Secure Care Tester 135. • SSD created information cards that were placed in the front office with a picture of the residents who are at risk for elopement and updated elopement binders placed at the nurse’s stations and front desk.	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255145	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD HEALTH AND REHABILITATION	**501 SOUTH LOCUST STREET , MCCOMB, Mississippi, 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
F0689 SS = SQC-J	Continued from page 10 • On 8/7/25 DON initiated Quality Observation, Monitoring of visitor's entry and exits to ensure Resident's do not leave out of the facility without staff knowledge. This will be done 2 times a day, during receptionist hours, 5 days a week, times 3 months per ADON/Designee. • Quality Assurance Performance Committee (QAPI) met on 8/7/25 at 2:00 PM to review the events of Resident #1's exit from facility and determine a Root Cause. Attendees were Executive Director (ED), Social Services Director (SSD), Business Office Manager (BOM), Director of Nursing (DON), Activities Director (AD), Therapy Manager (TM), Maintenance Supervisor (MS), Licensed Nurse (LPN) #1 and Medical Records Clerk (MRC) and IP. The Root Cause was determined to be that Resident #1 exited door when a visitor was entering. Education: On 8/7/25 and 8/8/25, In-Service education was conducted by the Director of Clinical Services on" Elopement Policy", "Procedure for Missing Resident ", and emphasis on ensuring complete closure of door when letting visitors in/out. This was a 100% mandatory education, and all employees will receive training upon hire and prior to taking assignment. The Facility alleges all corrective actions were completed on 8/8/2025 and the immediate jeopardy was removed on 8/9/2025, prior to the State Agency entrance on 8/11/2025. On 8/13/25 the SA validated through observation, interview and record review that the facility had completed all corrective actions on 8/8/2025 and the Immediate Jeopardy was removed on 8/9/2025, prior to the State Agency entrance on 8/11/2025.	F0689		