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 10/20/2025

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 Investigation (CI), MS # 2641013, at the facility from 10/16/25 through 10/20/25. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid. The SA investigated CI MS# 2641013 for quality-of-care treatment and resident/patient/client rights and citied F600 and F689. On 09/10/2025 through 10/12/25, the facility neglected to protect residents and staff from a resident with known violent and aggressive behaviors, resulting in ongoing threats, barricading incidents, and unsafe conditions for his roommate and others. Resident #1 was admitted on 9/9/25, with a documented history of aggression, and on 9/11/25, he threatened staff and residents but was allowed to remain in the facility with a roommate and without one-to-one supervision until 9/23/25, when he was sent to a behavioral health unit. Upon his return on 10/10/25, the resident again demonstrated violent behavior, and on 10/12/25, he barricaded himself and another resident in a room, requiring police intervention. The facility failed to provide prevent the residents right to be free from abuse and provide adequate supervision and to mitigate known environmental risks, such as unrestricted shared-bathroom access and unsecured objects, after the resident repeatedly barricaded doors, issued death threats, and threw a fire extinguisher, placing his roommate and others in the area at risk for serious harm. During the investigation of the complaint, the SA identified Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 9/10/25 and existed at: 42 CFR §483.12(a)(1) Free from Abuse and Neglect (F600) - S/S of "J" 42 CFR(s): 483.25(d)(1)(2) Free of Accidents Hazards/Supervision/Devices (F689) - Scope and Severity (S/S) of "J". The facility's failure to provide adequate supervision	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 to prevent the ongoing threats, of Resident #1 placed this resident, and other residents at risk for violent behavior, in a situation that was likely to cause serious injury, harm, impairment, or death. The SA notified the facility's Administrator of the IJ and SQC on 10/17/2025 at 12:51 PM and provided the Administrator with the IJ template. The facility submitted an acceptable Removal Plan on 10/17/2025, in which they alleged all corrective actions to remove the IJ were completed 10/17/2025 and the IJ removed on 10/18/2025. The SA validated the Removal Plan on 10/20/2025 and determined the IJ was removed on 10/18/2025, prior to exit. Therefore, the scope and severity of 42 CFR §483.12(a)(1)Free from Abuse and Neglect (F600), and CFR 483.25(d)(1)(2) Free of Accidents Hazard/Supervision/Devices (F689) was lowered to a Scope and Severity of "D" while the facility develops a plan of correction to monitor the effectiveness of systemic changes to ensure the facility sustains compliance with regulatory requirements. At the time of the survey, the facility was licensed for 145 beds and had a census of 113 residents.	F0000		
F0600 SS = SQC-J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review and facility policy review, the facility failed to ensure	F0600		

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F0600 SS = SQC-J	Continued from page 2 that residents were free from abuse, neglect, and intimidation when it admitted and retained a resident with known aggressive and violent behaviors (Resident #1) without implementing adequate supervision, behavioral interventions, or protective measures for other residents. The facility's failure to provide necessary psychiatric intervention or to relocate vulnerable roommates placed residents at risk for serious injury, harm, impairment, or death, resulting in an immediate jeopardy to resident health and safety. This deficient practice directly affected three (3) of four (4) sampled residents. Resident #2, Resident #3, and Resident #4. The facility failed to ensure that residents were free from abuse and neglect when it did not provide adequate supervision or implement effective interventions to prevent the ongoing aggressive and combative behaviors of Resident #1. This failure resulted in an unsafe environment and placed Resident #1 and other residents at risk for serious injury, harm, impairment, or death. During the investigation of the complaint, the SA identified Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 9/10/25 and existed at: 42 CFR §483.12(a)(1) Free from Abuse and Neglect (F600) - Scope/Severity (S/S) of "J" The SA notified the facility's Administrator of the IJ and SQC on 10/17/2025 at 12:51 PM and provided the Administrator with the IJ templates. The facility submitted an acceptable removal plan on 10/17/25 in which the facility alleged all corrective actions were completed on 10/17/25 and the IJ was removed on 10/18/25, therefore, the scope and severity of 42 CFR §483.12(a)(1)Free from Abuse and Neglect (F600), was lowered to a scope and severity of "D" while the facility develops a plan of correction to monitor the effectiveness of systemic changes to ensure the facility sustains compliance with regulatory requirements. Cross Reference: F689 Findings include: A record review of the "Abuse, Neglect and Exploitation Policy" with implementation date of 6/1/25 revealed, "Policy: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written	F0600		

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F0600 SS = SQC-J	Continued from page 3 policies and procedures that prohibit and prevent abuse…" IV. Identification of Abuse. Possible indicators of abuse include, but are not limited to: 1. Resident or staff report of abuse… 5. Verbal Abuse… 7. Psychological abuse of a resident observed… 10. Sudden or unexplained changes in behaviors and/or activities, such as fear of a person…" At 11:03 AM, on 10/16/25, in an interview with Resident #2, who shares an adjoining room with Resident #1, he revealed that there were multiple times when Resident #1 would come through their adjoining bathroom door and yell at him while he was in bed at night, cussing and making threats that he was going to harm him. He said he could not sleep while "that man" was next door. He stated that he simply did not feel safe while Resident #1 was staying next door. He indicated that all staff were aware of what was happening and were attempting to calm Resident #1 and prevent him from entering his room. At 11:46 AM, on 10/16/25, in an interview with Resident #1's roommate, who is Resident #4 explained that Resident #1 cursed at him, called him names, and made threats, stating he was going to kill him. However, these incidents did not occur frequently. When he pressed the call light, the staff would come and try to calm Resident #1 down. The most recent time was when they tried to calm Resident #1, but he barricaded them in the room, preventing anyone from coming in. At 11:55 AM, in an interview with Resident #3, who is in a room across the hall from Resident #1, revealed that she was afraid of Resident #1 and would not come out of her room when he was yelling in the halls. At 12:10 PM, on 10/16/25, in an interview with Licensed Practical Nurse (LPN) #1, she revealed that on Sunday, 10/12/25, during the 1:30 PM smoke break, she observed Resident #2 crying and saying, "That boy down there," out of frustration and because he was tired of him being there. During an interview with the Registered Nurse (RN) Unit Manager at 12:38 PM, on 10/16/25, the resident explained Resident #1's initial behaviors, which started when he first admitted, when his medication nurse reported to her that the resident was refusing to take medications, taking medications off her cart, and making it difficult for her to pass meds. When she went to investigate, she found him standing in the doorway of his room. She attempted to give him his medicine, but he refused and walked down the hall, threatening to kill everyone. At that point, she still did not	F0600		

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F0600 SS = SQC-J	Continued from page 4 identify him as a danger to himself or the residents. A few days later, she reported that he chased her back to the nurse's station and cornered her. She indicates that it was during that incident that she contacted her Assistant Director of Nursing (ADON), who was in her office at the time, via text to inform her and the Director of Nursing (DON) about what had happened, stating that he needed to be sent out due to uncontrollable aggressive behaviors. She went on to say that during this time, Resident #2 was very afraid of Resident #1 and wouldn't go to the bathroom because it adjoined Resident #1's bathroom. To ease him, she and the other nurses watched Resident #2 and assured him they would protect him. However, she was unsure whether anyone monitored the resident at night to ensure his safety. She indicates that during all of this, neither Resident #2 nor Resident #4 was moved to another room. She admits that it is unfair for residents to be in an environment where they had to fear another resident attacking them. On 10/16/25 at 1:29 PM, in an interview with the ADON, she revealed that Resident #1 prevented nurses from checking on him and his roommate, which meant the roommate could not receive his medication. She said this was not the first time Resident #1 had done this. She stated he would go into other rooms and prevent staff from entering. She confirmed that Resident #2 was afraid to use the adjoining bathroom and is not aware of any interventions in place for him during those times. In a follow-up interview with the DON at 3:02 PM, on 10/16/25, she revealed that the staff's first attempt to send the resident out was on 9/11/25, but they were not successful until 9/23/25. At 3:32 PM, on 10/16/25, LPN #2, who serves as the medication nurse, recalled that Resident #2 was the most affected by Resident #1's behaviors. At times, he was afraid to go into his room because Resident #1 was next door, so he spent more time in activities to be around others. She said no formal interventions were put in place other than verbally trying to comfort Resident #2, such as telling him everything would be ok. Record review of the "Progress Notes" dated 9/11/25 at 3:57 PM Resident #1 refused Haldol and accused the nurse of trying to kill him. Staff were unable to redirect him. Between 4:40 PM and 5:08 PM, he exhibited a series of escalating behaviors, including pacing, yelling profanities, threatening staff with harm, and charging at a nurse, with staff again unable to	F0600		

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F0600 SS = SQC-J	Continued from page 5 redirect or approach. Record review of the “Progress Notes” dated 9/14/25 at 11:53 PM, Resident #1 became agitated over the volume of the television, refused to wear his wander guard, and was up all-night disturbing others. Record review of the “Progress Notes” dated 10/10/25, at 7:04 PM, Resident #1 made inappropriate sexual comments to a nurse, stating, “You turning me on,” and repeated the statement three times. Record review of the “Progress Notes” dated 10/11/25 at 1:36 PM, he made additional sexual comments and was observed touching himself inappropriately, which caused staff discomfort. Between 4:33 PM and 4:43 PM Resident #1 threatened to kill staff, ran hot water in an attempt to scald someone, tore up the window blinds, screamed threats at his roommate, threw shoe soles, refused to sleep, and played the television at an excessively high volume. Record review of the “Progress Notes” dated 10/12/25 at 7:37 AM, Resident #1 was transferred to the hospital after Resident #1 continued to exhibit behaviors including manic behavior, including yelling, slamming doors, speaking loudly, waking other residents, threatening staff, and attempting to attack someone. Resident #1 continued to be aggressive, yelling, pushing furniture into a nurse, blocking doors, threatening his roommate, and ultimately requiring intervention from both police and emergency medical services. Record review of the "Progress Notes" dated 10/12/25 at 12:00 PM, revealed Resident #1 returned to the facility. After returning from the emergency room, he refused to remain in his room, continued pacing, and required one-on-one supervision. Resident #1 remained combative, refused to have his vital signs taken. At 2:30 PM documentation revealed Resident #1 again threatened staff, barricaded another resident’s room, and threw a fire extinguisher, prompting another call to police. Resident #1 A record review of the "Admission Record" revealed the facility admitted Resident #1 on 9/9/25 with diagnoses including Schizoaffective Disorder, Bipolar Type, Schizophrenia, and Suicidal Ideation. A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/15/25 revealed a	F0600		

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F0600 SS = SQC-J	Continued from page 6 Brief Interview Mental Score (BIMS) score of five (5) indicating Resident #1 had severe cognitive impairment. Resident #2 A record review of the "Admission Record" revealed the facility admitted Resident #2 on 2/6/25 with diagnoses including Major Depressive Disorder. A record review of the quarterly MDS with an ARD of 8/16/25 revealed a BIMS score of (15) indicating the resident was cognitively intact. Resident #3 A record review of the "Admission Record" revealed the facility admitted Resident #3 on 9/15/25 with diagnoses including Chronic Obstructive Pulmonary Disease (COPD). A record review of the MDS with an ARD of 9/21/25 revealed a BIMS score of (15) indicating the Resident #3 was cognitively intact. Resident #4 A record review of the "Admission Record" revealed the facility admitted Resident #4 on 9/28/23 with diagnoses including Hemiplegia and Hemiparesis affecting the Right Non-Dominant Side. A record review of the annual MDS with an ARD of 9/26/25 revealed a BIMS score of (14) indicating the Resident #4 was cognitively intact. Removal Plan: Facility failed to provide adequate supervision to protect Residents from a known safety hazard caused by Resident # 1 with a documented history of aggression and violence. Staff failed to implement continuous monitoring, relocate roommates, or remove environmental risks after the Resident repeatedly barricaded rooms, made death threats, and threw a fire extinguisher. 10/12/25 at 6:46 AM Resident #1's physician and Resident Representative was notified by the Licensed Nurse #1 of Resident barricading himself in his room by pushing the bed against the door and threatening staff verbally and physically. Licensed Practical Nurse (LPN) 1 then called 911 emergency services. Local police were dispatched and arrived at the facility at 7:06 AM. Ambulance arrived at approximately 7:37 AM and transported Resident #1 to local Emergency Department. Emergency department notified Director of Nursing (DON)	F0600		

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F0600 SS = SQC-J	Continued from page 7 at 11: O5 AM requesting that Resident #1 be picked up from Emergency Department. Resident #1 was transported back to facility-by-facility staff and arrived back at 12:00 PM. Resident #1 was placed in a private room upon return and placed on one-on-one supervision. Resident continued pacing threatening staff and threw the extinguisher to ground. At 2:30 PM Resident #1 barricaded the door to another Residents room. Staff notified police and ambulance service. Resident # 1's physician was notified, and physician orders noted for Haldol 5 mg Intramuscular every six (6) hours as needed for psychosis related to Schizophrenia. Ambulance arrived and Resident # 1 was transported to the local emergency department a second time. Resident #1 was transported from the Emergency Department to the inpatient behavioral health facility. Resident # 1 remains in inpatient behavioral health facility. Once Resident #1 exited facility the fire extinguisher was mounted back securely, and the beds were placed with wheels locked to remove barricade risk was removed. On 10/12/25 the Executive Director interviewed Resident that was barricaded in room with Resident # 1 and asked if he was ok and was, he was afraid. Resident indicated that he was not afraid. On 10/13/25 facility issued an emergency notification of discharge to residents' family at 10: 13 AM. Social Services Director began searching for alternative placement. Resident #1 will not return to the facility until cleared and appropriate safeguards are in place. Education was initiated with all facility staff on 10/16/25 by the Director of Nursing on Abuse and Neglect Policy with emphasis on Resident's psychosocial harm, de-escalation of behavioral episodes and investigation of psychosocial harm. Staff will be educated prior to accepting assignment. Education was conducted on 10/16/25 with the Executive Director and Director of Nursing by the Regional Director of Clinical Services on investigation post behavioral episodes for psychosocial harm of Residents. Interview with current Residents with a Brief Interview Mental Status (BIMS) or 10 or greater was conducted by the Social Services Director, Social Services Assistant, and the Assistant Director of Nursing on 10/16/25 and 10/17/25 to assess for any psychosocial harm or Incident of trauma. On 10/17/25 Residents #2, #3 and #4's Care Plans were	F0600		

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F0600 SS = SQC-J	Continued from page 8 updated to Include Trauma Centered care. Quality Assurance Performance Improvement (QAPI) Committee met on 10/17/25 at 2:00 PM. Attendees were the Medical Director, Executive Director, Director of Nursing, Social Services Director, Minimum Data Set Nurse, Unit Manager, Business Development, Regional Director of Nursing, Medical R cords Clerk, Assistant Director of Nursing, Treatment Nurse, Infection Control Preventionist, Maintenance Director and Human Resources Director. Abuse Neglect Policy, Behavioral Health Policy and Accidents and Supervision Policy was reviewed with no changes made. The facility alleges all corrective actions were completed on 10/17/25 and the Immediate Jeopardy was removed on 10/18/25. Corrective Actions:The Director of Nursing started an all-staff in-service on Abuse/ Neglect policy with emphasis on resident psychosocial harm and abuse de-escalation of behavioral episodes and an investigation of psychosocial harm that concluded 10/20/25. Affected residents care plans were updated on 10/16/25 to reflect trauma informed care by the Care Plan team. The Regional Director in-serviced the Administrator and the Director of Nursing on 10/17/25 regarding Abuse/Neglect, Investigations of Psychosocial Harm, Behavioral Services, De-escalations and Accidents and Hazards. An Emergency Quality Assurance Committee was held on 10/17/25 with the following staff in attendance: Regional Director, Executive Director, Director of Nursing, MDS Nurse, Business Development Services, Social Services Director, Assistant Director of Nursing, Environmental Services, Maintenance Director and Infection Prevention Nurse. The facility completed all actions to remove the Immediate Jeopardies on 10/17/25 and alleges the IJ was removed on 10/18/25. On 10/20/25, the State Agency (SA) validations were made onsite during the complaint investigation through interviews and record reviews that all corrective actions had been taken by the facility to remove the IJ and the IJ was removed on 10/18/25.	F0600		
F0689 SS = SQC-J	Free of Accident Hazards/Supervision/Devices	F0689		

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F0689 SS = SQC-J	Continued from page 9 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, and record review, the facility failed to ensure that residents were protected from a resident who was admitted with known aggressive behaviors and failed to provide adequate supervision and interventions for that resident. The facility admitted and continued to retain Resident #1 without ensuring appropriate psychiatric care, enhanced supervision, or reassignment of vulnerable roommates. This systemic failure directly affected three (3) of four (4) sampled residents. Resident #2, Resident #3, and Resident #4. The facility's failure to provide adequate supervision to prevent the exhibited aggressive and combative behaviors of Resident #1 placed this resident, and other residents at risk, in a situation that was likely to cause serious injury, harm, impairment, or death. The facility's failure to identify the need for adequate supervision and ensure a secure environment contributed to Resident #1's exhibited aggressive and combative behaviors and placed all residents who were admitted with at risk. This failure resulted in Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 09/10/25. The IJ and SQC existed at: CFR 483.25(d)(1)(2) Free of Accidents Hazard/Supervision/Devices (F689) Scope and Severity (S/S) - J The SA notified the facility's Administrator of the IJ and SQC on 10/17/2025 at 12:51 PM and provided the Administrator with the IJ templates. The facility submitted an acceptable removal plan on 10/17/25 in which the facility alleged all corrective	F0689		

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F0689 SS = SQC-J	Continued from page 10 actions were completed on 10/17/25 and the IJ was removed on 10/18/25, therefore, the scope and severity of 42 CFR §483.12(a)(1)Free from Abuse and Neglect (F600), was lowered to a scope and severity of "D" while the facility develops a plan of correction to monitor the effectiveness of systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: On 10/16/25 at 12:38 PM, during an interview the Registered Nurse (RN) Unit Manager stated that Resident #1 was admitted on 9/9/25 and had such behaviors as refusing medications and threatening to harm staff. This escalated to him chasing her toward the nurse's station and cornering her against the wall. As a result, she contacted her Assistant Director of Nursing (ADON) and other administrative staff via group text. She requested that the resident be sent out because he could not be redirected. However, there were no beds available at the two behavioral centers they called, so Resident #1 had to stay at the facility until one became available. She revealed that the adjoining roommate, Resident #2, was fearful and not relocated. She indicates that while other nurses monitored Resident #2 during the day shift, she is unaware whether anyone watched the resident at night and acknowledges that it was not fair for residents to remain in fear. On 10/16/25 at 1:29 PM, during an interview the ADON stated that Resident #1 refused medications, at one point trapped his roommate by preventing staff entry, barricaded himself in another resident's room, slammed a fire extinguisher, and required police intervention. She stated his admission records indicated violent behavior, but at times he was calm. On 10/16/25 at 1:57 PM, during an interview the Director of Nursing (DON) confirmed the resident was discharged on 10/12/25. She explained that the admission records reflected paranoia and psychosis, but she was unaware of the extent of violent behaviors, acknowledged that the roommate or the adjoining resident was not relocated, and stated she would have moved them had she known the risk. On 10/16/25 at 12:10 PM, Licensed Practical Nurse (LPN) #1 reported that on 10/11/25 she observed the resident in the bathroom doorway holding a Bible and clippers saying, "I'm going to kill you." She stated that she documented but did not notify supervisory nurses, and that the following day the resident again barricaded	F0689		

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F0689 SS = SQC-J	Continued from page 11 himself in the room, requiring police to be notified. She observed Resident #2, who resided in the adjoining room, crying on the smoking porch due to fear. On 10/16/25 at 3:32 PM, during an interview, LPN #2 reported Resident #1 paced at night, entered other residents' rooms, and yelled and threatened when redirected, and that Resident #2 was impacted as he avoided his room at times, and stayed in activities during the day, and refused to go to use the adjoining bathroom at night due to fear. LPN#2 stated that no interventions beyond verbal reassurance were implemented and that there was no relocation of the roommate because the resident was not aggressive all the time. On 10/16/25 at 11:02 AM, during an interview Resident #2 explained he had the adjoining room to Resident #1, who repeatedly entered through the shared bathroom, yelled, cursed, and threatened him with harm. He stated that he could not sleep and did not feel safe. He stated that staff were aware and attempted redirection for Resident #1 and that police ultimately intervened. On 10/16/25 at 11:46 AM, in an interview with Resident #4 stated that Resident #1 cursed and threatened to kill him. He stated that he activated the call light and that Resident #1 barricaded the door, preventing staff entry, and that the police removed the resident. On 10/16/25 at 11:55 AM, during an interview, Resident #3, who lives across the hall, reported being afraid to leave her room because the resident would yell and pace the halls at night. Record review of the "Progress Notes" dated 9/11/25 at 3:57 PM Resident #1 refused Haldol and accused the nurse of trying to kill him. Staff were unable to redirect him. Between 4:40 PM and 5:08 PM, he exhibited a series of escalating behaviors, including pacing, yelling profanities, threatening staff with harm, and charging at a nurse, with staff again unable to redirect or approach. Record review of the "Progress Notes" dated 9/14/25 at 11:53 PM, Resident #1 became agitated over the volume of the television, refused to wear his wander guard, and was up all-night disturbing others. Record review of the "Progress Notes" dated 10/10/25, at 7:04 PM, Resident #1made inappropriate sexual comments to a nurse, stating, "You turning me on," and repeated the statement three times.	F0689		

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F0689 SS = SQC-J	Continued from page 12 Record review of the “Progress Notes” dated 10/11/25 at 1:36 PM, he made additional sexual comments and was observed touching himself inappropriately, which caused staff discomfort. Between 4:33 PM and 4:43 PM Resident #1 threatened to kill staff, ran hot water in an attempt to scald someone, tore up the window blinds, screamed threats at his roommate, threw shoe soles, refused to sleep, and played the television at an excessively high volume. Record review of the “Progress Notes” dated 10/12/25 between 1:44 PM and 3:46PM, Resident #1 demonstrated manic behavior, including yelling, slamming doors, speaking loudly, waking other residents, threatening staff, barricading rooms, throwing a fire extinguisher, and attempting to attack someone. From 4:05 PM to 7:26 PM, he continued to be aggressive, yelling, pushing furniture into a nurse, blocking doors, threatening his roommate, and ultimately requiring intervention from both police and emergency medical services. Between 10:29 PM and 12:00 AM, after returning from the emergency room, he refused to remain in his room, continued pacing, and required one-on-one supervision. From 12:00 AM to 4:30 PM, Resident #1 again threatened staff, barricaded another resident’s room, and threw a fire extinguisher, prompting another call to police. Between 3:50 PM and 4:16 PM, Resident #1 remained combative, refused to have his vital signs taken, and triggered drug interaction alerts due to his antipsychotic medication regimen. Resident #1 A record review of the "Admission Record" revealed the facility admitted Resident #1 on 9/9/25 with diagnoses including Schizoaffective Disorder, Bipolar Type, Schizophrenia, and Suicidal Ideation. A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/15/25 revealed a Brief Interview for Mental Status (BIMS) score of five (5) indicating Resident #1 had severe cognitive impairment. Resident #2 A record review of the "Admission Record" revealed the facility admitted Resident #2 on 2/6/25 with diagnoses including Major Depressive Disorder. A record review of the quarterly MDS with an ARD of 8/16/25 revealed a BIMS score of (15) indicating the resident was cognitively intact.	F0689		

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F0689 SS = SQC-J	Continued from page 13 Resident #3 A record review of the "Admission Record" revealed the facility admitted Resident #3 on 9/15/25 with diagnoses including Chronic Obstructive Pulmonary Disease (COPD). A record review of the MDS with an ARD of 9/21/25 revealed a BIMS score of (15) indicating the Resident #3 was cognitively intact. Resident #4 A record review of the "Admission Record" revealed the facility admitted Resident #4 on 9/28/23 with diagnoses including Hemiplegia and Hemiparesis affecting the right non-dominant side. A record review of the annual MDS with an ARD of 9/26/25 revealed a BIMS score of (14) indicating the Resident #4 was cognitively intact. Removal Plan: Facility failed to provide adequate supervision to protect Residents from a known safety hazard caused by Resident # 1 with a documented history of aggression and violence. Staff failed to implement continuous monitoring, relocate roommates, or remove environmental risks after the Resident repeatedly barricaded rooms, made death threats, and threw a fire extinguisher. 10/12/25 at 6:46 AM Resident #1's physician and Resident Representative was notified by the Licensed Nurse #1 of Resident barricading himself in his room by pushing the bed against the door and threatening staff verbally and physically. Licensed Practical Nurse (LPN) 1 then called 911 emergency services. Local police were dispatched and arrived at the facility at 7:06 AM. Ambulance arrived at approximately 7:37 AM and transported Resident #1 to local Emergency Department. Emergency department notified Director of Nursing (DON) at 11:05 AM requesting that Resident #1 be picked up from Emergency Department. Resident #1 was transported back to facility-by-facility staff and arrived back at 12:00 PM. Resident #1 was placed in a private room upon return and placed on one-on-one supervision. Resident continued pacing threatening staff and threw the extinguisher to ground. At 2:30 PM Resident #1 barricaded the door to another Residents room. Staff notified police and ambulance service. Resident # 1's physician was notified, and physician orders noted for Haldol 5 mg Intramuscular every six (6) hours as needed for psychosis related to Schizophrenia. Ambulance arrived and Resident # 1 was transported to the local	F0689		

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F0689 SS = SQC-J	Continued from page 14 emergency department a second time. Resident #1 was transported from the Emergency Department to the inpatient behavioral health facility. Resident # 1 remains in inpatient behavioral health facility. Once Resident #1 exited facility the fire extinguisher was mounted back securely, and the beds were placed with wheels locked to remove barricade risk was removed. On 10/12/25 the Executive Director interviewed Resident that was barricaded in room with Resident # 1 and asked if he was ok and was, he was afraid. Resident indicated that he was not afraid. On 10/13/25 facility issued an emergency notification of discharge to residents' family at 10: 13 AM. Social Services Director began searching for alternative placement. Resident #1 will not return to the facility until cleared and appropriate safeguards are in place. Education was initiated with all facility staff on 10/16/25 by the Director of Nursing on Abuse and Neglect Policy with emphasis on Resident's psychosocial harm, de-escalation of behavioral episodes and investigation of psychosocial harm. Staff will be educated prior to accepting assignment. Education was conducted on 10/16/25 with the Executive Director and Director of Nursing by the Regional Director of Clinical Services on investigation post behavioral episodes for psychosocial harm of Residents. Interview with current Residents with a Brief Interview Mental Status (BIMS) or 10 or greater was conducted by the Social Services Director, Social Services Assistant, and the Assistant Director of Nursing on 10/16/25 and 10/17/25 to assess for any psychosocial harm or Incident of trauma. On 10/17/25 Residents #2, #3 and #4's Care Plans were updated to Include Trauma Centered care. Quality Assurance Performance Improvement (QAPI) Committee met on 10/17/25 at 2:00 PM. Attendees were the Medical Director, Executive Director, Director of Nursing, Social Services Director, Minimum Data Set Nurse, Unit Manager, Business Development, Regional Director of Nursing, Medical R cords Clerk, Assistant Director of Nursing, Treatment Nurse, Infection Control Preventionist, Maintenance Director and Human Resources Director. Abuse Neglect Policy, Behavioral Health Policy and Accidents and Supervision Policy was reviewed with no changes made.	F0689		

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F0689 SS = SQC-J	Continued from page 15 The facility alleges all corrective actions were completed on 10/17/25 and the Immediate Jeopardy was removed on 10/18/25. Corrective Actions:The Director of Nursing started an all-staff in-service on Abuse/ Neglect policy with emphasis on resident psychosocial harm and abuse de-escalation of behavioral episodes and an investigation of psychosocial harm that concluded 10/20/25. Affected residents care plans were updated on 10/16/25 to reflect trauma informed care by the Care Plan team. The Regional Director in-serviced the Administrator and the Director of Nursing on 10/17/25 regarding Abuse/Neglect, Investigations of Psychosocial Harm, Behavioral Services, De-escalations and Accidents and Hazards. An Emergency Quality Assurance Committee was held on 10/17/25 with the following staff in attendance: Regional Director, Executive Director, Director of Nursing, MDS Nurse, Business Development Services, Social Services Director, Assistant Director of Nursing, Environmental Services, Maintenance Director and Infection Prevention Nurse. The facility completed all actions to remove the Immediate Jeopardies on 10/17/25 and alleges the IJ was removed on 10/18/25. On 10/20/25, the State Agency (SA) validations were made onsite during the complaint investigation through interviews and record reviews that all corrective actions had been taken by the facility to remove the IJ and the IJ was removed on 10/18/25.	F0689		